S. HRG. 108–199

INDIAN HEALTH CARE IMPROVEMENT ACT

JOINT HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

AND THE

COMMITTEE ON RESOURCES
UNITED STATES HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

S. 556

TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND THAT ACT

AND

H.R. 2440

TO IMPROVE THE IMPLEMENTATION OF THE FEDERAL RESPONSIBILITY FOR THE CARE AND EDUCATION OF INDIAN PEOPLE BY IMPROVING THE SERVICES AND FACILITIES OF FEDERAL HEALTH PROGRAMS FOR INDIANS AND ENCOURAGING MAXIMUM PARTICIPATION OF INDIANS IN SUCH PROGRAMS

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APPENDIX

INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 16, 2003

U.S. SENATE, COMMITTEE ON INDIAN AFFAIRS, MEETING JOINTLY WITH THE COMMITTEE ON RESOURCES, U.S. HOUSE OF REPRESENTATIVES

Washington, DC.

The committees met, pursuant to notice, at 10:15 a.m. in room 106, Dirksen Senate Office Building, Hon. Ben Nighthorse Campbell (chairman of the Senate Committee on Indian Affairs) presiding.

Present from the Senate Committee on Indian Affairs: Senators Campbell, Inouye, Reid, Conrad, Dorgan, and Murkowski.

Present from the House of Representatives Committee on Resources: Representatives Pombo, Mark Udall, Faleomavaega, Cole, Kildee, Grijalva, Pallone, Brad Carson, Christensen, and Napolitano.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. We will now move to the joint hearing with the House Resources Committee and the Senate Committee on Indian Affairs bills to reauthorize the Indian Health Care Improvement Act. The two bills before our committee, S. 556 and H.R. 2440, reflect literally years of hard work by tribal leaders, the National Steering Committee and various Federal officials.

Most members know the shameful state of Indian health. Senator Dorgan just reiterated that as did Senator Conrad, so I won't go through the litany of statistics this morning but they are common knowledge.

Today is the second in a series of hearings on the reauthorization bill. We will receive testimony regarding one, health disparities; two, health facilities; and three, urban Indian health issues. In the interest of time, I'll place my full statement in the record but I will say this to the members of both committees. After years of work and countless hours of meetings and hearings, the time certainly has come for the tribes, Congress and the Administration to roll up our sleeves and do what we need to do to move this bill and get the act reauthorized this year. To achieve that goal I look forward to working with my colleagues on both committees.

[Prepared statement of Senator Campbell appears in appendix.]

[Text of S. 556 and H.R. 2440 follow:]

II

108TH CONGRESS
1ST SESSION

S. 556

To amend the Indian Health Care Improvement Act to revise and extend that Act.

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

Mr. CAMPBELL (for himself, Mr. INOUYE, and Mr. MCCAIN) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Health Care Improvement Act Reauthorization of 2003''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—REAUTHORIZATION AND REVISIONS OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IMPROVEMENT ACT.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

''(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

''(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

''SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the

Constitution, treaties, Federal laws, and the course of dealings of the United States with Indian tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

''(2) From the time of European occupation and colonization through the 20th century, the policies and practices of the United States caused or contributed to the severe health conditions of Indians.

''(3) Indian tribes have, through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

''(4) The population growth of the Indian people that began in the later part of the 20th century increases the need for Federal health care services.

''(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than

that of the general population, and to provide for the maximum participation of Indian tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

''(6) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

''(7) Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.

''(8) The disparity in health status that is to be addressed is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people—

"(1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto;

"(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto, to permit Indian tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

"(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each geographic service area is raised to at least the level of that of the general population;

''(5) to require meaningful, active consultation with Indian tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

''(6) that funds for health care programs and facilities operated by tribes and tribal organizations be provided in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.

''SEC. 4. DEFINITIONS.

''In this Act:

''(1) ACCREDITED AND ACCESSIBLE.—The term 'accredited and accessible', with respect to an entity, means a community college or other appropriate entity that is on or near a reservation and accredited by a national or regional organization with accrediting authority.

''(2) AREA OFFICE.—The term 'area office' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

''(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary of the Indian Health as established under section 601.

''(4) CONTRACT HEALTH SERVICE.—The term 'contract health service' means a health service that is provided at the expense of the Service, Indian tribe, or tribal organization by a public or private medical provider or hospital, other than a service funded under the Indian Self-Determination and Education Assistance Act or under this Act.

''(5) DEPARTMENT.—The term 'Department', unless specifically provided otherwise, means the Department of Health and Human Services.

''(6) FUND.—The terms 'fund' or 'funding' mean the transfer of monies from the Department to any eligible entity or individual under this Act by any legal means, including funding agreements, contracts, memoranda of understanding, Buy Indian Act contracts, or otherwise.

''(7) FUNDING AGREEMENT.—The term 'funding agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, functions, services and activities to tribes and tribal organizations from the Secretary under the authority of the Indian Self-Determination and Education Assistance Act.

''(8) HEALTH PROFESSION.—The term 'health profession' means allopathic medicine, family medi-

cine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, and allied health professions, or any other health profession.

''(9) HEALTH PROMOTION; DISEASE PREVENTION.—The terms 'health promotion' and 'disease prevention' shall have the meanings given such terms in paragraphs (1) and (2) of section 203(c).

''(10) INDIAN.—The term 'Indian' and 'Indians' shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.

''(11) INDIAN HEALTH PROGRAM.—The term 'Indian health program' shall have the meaning given such term in section 110(a)(2)(A).

''(12) INDIAN TRIBE.—The term 'Indian tribe' shall have the meaning given such term in section 4(e) of the Indian Self Determination and Education Assistance Act.

''(13) RESERVATION.—The term 'reservation' means any federally recognized Indian tribe's res-

ervation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

''(14) SECRETARY.—The term 'Secretary', unless specifically provided otherwise, means the Secretary of Health and Human Services.

''(15) SERVICE.—The term 'Service' means the Indian Health Service.

''(16) SERVICE AREA.—The term 'service area' means the geographical area served by each area office.

''(17) SERVICE UNIT.—The term 'service unit' means—

''(A) an administrative entity within the Indian Health Service; or

''(B) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

''(18) TRADITIONAL HEALTH CARE PRACTICES.—The term 'traditional health care practices'

means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to western healing sciences) which embodies the influences or forces of innate tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which calls upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation and maintenance of health, well-being, and life's harmony.

''(19) TRIBAL ORGANIZATION.—The term 'tribal organization' shall have the meaning given such term in section 4(l) of the Indian Self Determination and Education Assistance Act.

''(20) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' shall have the meaning given such term in section 126 (g)(2).

''(21) URBAN CENTER.—The term 'urban center' means any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

"(22) URBAN INDIAN.—The term 'urban Indian' means any individual who resides in an urban center and who—

"(A) for purposes of title V and regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those tribes, bands or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member;

"(B) is an Eskimo or Aleut or other Alaskan Native;

"(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(D) is determined to be an Indian under regulations promulgated by the Secretary.

"(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which is capable of legally cooperating with other public and private

entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

''(a) SERVICE AREA PRIORITIES.—Unless specifically provided otherwise, amounts appropriated for each fiscal year to carry out each program authorized under this title shall be allocated by the Secretary to the area office of each service area using a formula—

''(1) to be developed in consultation with Indian tribes, tribal organizations and urban Indian organizations;

''(2) that takes into account the human resource and development needs in each such service area; and

''(3) that weighs the allocation of amounts appropriated in favor of those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians in all service areas, except that amounts allocated to each such area using such a weighted allocation formula shall not be less than the amounts allocated to each such area in the previous fiscal year.

''(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

''(c) REALLOCATION.—Unless specifically prohibited, an area office may reallocate funds provided to the office under this title among the programs authorized by this title, except that scholarship and loan repayment funds shall not be used for administrative functions or expenses.

''(d) LIMITATION.—This section shall not apply with respect to individual recipients of scholarships, loans or other funds provided under this title (as this title existed 1 day prior to the date of enactment of this Act) until

such time as the individual completes the course of study that is supported through the use of such funds.

"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available through the area office to public or nonprofit private health entities, or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

''(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

''(A) to enroll in courses of study in such health professions; or

''(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

''(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

''(3) establishing other programs which the area office determines will enhance and facilitate the en-

rollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) ADMINISTRATIVE PROVISIONS.—

''(1) APPLICATION.—To be eligible to receive funds under this section an entity described in subsection (a) shall submit to the Secretary, through the appropriate area office, and have approved, an application in such form, submitted in such manner, and containing such information as the Secretary shall by regulation prescribe.

''(2) PREFERENCE.—In awarding funds under this section, the area office shall give a preference to applications submitted by Indian tribes, tribal organizations, or urban Indian organizations.

''(3) AMOUNT.—The amount of funds to be provided to an eligible entity under this section shall be determined by the area office. Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations promulgated pursuant to this Act.

''(4) TERMS.—A funding commitment under this section shall, to the extent not otherwise prohib-

ited by law, be for a term of 3 years, as provided for in regulations promulgated pursuant to this Act.

''(c) DEFINITION.—For purposes of this section and sections 104 and 105, the terms 'Indian' and 'Indians' shall, in addition to the definition provided for in section 4, mean any individual who—

''(1) irrespective of whether such individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940;

''(2) is an Eskimo or Aleut or other Alaska Native;

''(3) is considered by the Secretary of the Interior to be an Indian for any purpose; or

''(4) is determined to be an Indian under regulations promulgated by the Secretary.

''SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide scholarships through the area offices to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

''(2) have demonstrated the capability to successfully complete courses of study in the health professions.

''(b) PURPOSE.—Scholarships provided under this section shall be for the following purposes:

''(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act).

''(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

''(c) USE OF SCHOLARSHIP.—Scholarships made under this section may be used to cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school.

''(d) LIMITATIONS.—Scholarship assistance to an eligible applicant under this section shall not be denied solely on the basis of—

''(1) the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; or

''(2) the applicant's eligibility for assistance or benefits under any other Federal program.

''SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

''(a) SCHOLARSHIPS.—

''(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in accordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

''(2) NO DELEGATION.—The Director of the Service shall administer this section and shall not

delegate any administrative functions under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act.

''(b) ELIGIBILITY.—

''(1) ENROLLMENT.—An Indian shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a)(1).

''(2) SERVICE OBLIGATION.—

''(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

''(i) in the Indian Health Service;

''(ii) in a program conducted under a funding agreement entered into under the Indian Self-Determination and Education Assistance Act;

''(iii) in a program assisted under title V; or

"(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

"(i) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of

obligated service that is required under this section.

''(ii) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

''(iii) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (iv) of subparagraph (A).

''(C) NEW SCHOLARSHIP RECIPIENTS.—A recipient of an Indian Health Scholarship that is awarded after December 31, 2003, shall meet the active duty service obligation under such scholarship by providing service within the service area from which the scholarship was awarded. In placing the recipient for active duty the area office shall give priority to the program that funded the recipient, except that in cases of special circumstances, a recipient may be placed in a different service area pursuant to an agreement between the areas or programs involved.

''(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(3) PART-TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section who is enrolled part time in an approved course of study—

''(A) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the appropriate area office;

''(B) the period of obligated service described in paragraph (2)(A) shall be equal to the greater of—

''(i) the part-time equivalent of 1 year for each year for which the individual was

provided a scholarship (as determined by the area office); or

''(ii) two years; and

''(C) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254l(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

''(4) BREACH OF CONTRACT.—

''(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with the area office pursuant to a scholarship under this section and who—

''(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) is dismissed from such educational institution for disciplinary reasons;

''(iii) voluntarily terminates the training in such an educational institution for

which he or she is provided a scholarship under such contract before the completion of such training; or

''(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract;

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

''(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(C) DEATH.—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(D) WAIVER.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, determines that—

''(i) it is not possible for the recipient to meet that obligation or make that payment;

''(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(E) HARDSHIP OR GOOD CAUSE.—Notwithstanding any other provision of law, in any

case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

''(F) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

''(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

''(1) PROVISION OF FUNDS.—

''(A) IN GENERAL.—The Secretary shall make funds available, through area offices, to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

''(B) LIMITATION.—The Secretary shall ensure that amounts available for grants under subparagraph (A) for any fiscal year shall not exceed an amount equal to 5 percent of the amount available for each fiscal year for Indian Health Scholarships under this section.

''(C) APPLICATION.—An application for funds under subparagraph (A) shall be in such form and contain such agreements, assurances and information as consistent with this section.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—An Indian tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to Indians in accordance with the requirements of this subsection.

''(B) MATCHING REQUIREMENT.—With respect to the costs of providing any scholarship pursuant to subparagraph (A)—

''(i) 80 percent of the costs of the scholarship shall be paid from the funds provided under paragraph (1) to the Indian tribe or tribal organization; and

''(ii) 20 percent of such costs shall be paid from any other source of funds.

"(3) ELIGIBILITY.—An Indian tribe or tribal organization shall provide scholarships under this subsection only to Indians who are enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in this Act.

"(4) CONTRACTS.—In providing scholarships under paragraph (1), the Secretary and the Indian tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

"(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

"(i) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

"(ii) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;

"(B) provide that the scholarship—

"(i) may only be expended for—

"(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

"(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

"(ii) may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the

year for the purposes authorized in clause (i);

''(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to the health profession involved.

''(5) BREACH OF CONTRACT.—

''(A) IN GENERAL.—An individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under this subsection and who—

''(i) fails to maintain an acceptable level of academic standing in the education institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) is dismissed from such education for disciplinary reasons;

''(iii) voluntarily terminates the training in such an educational institution for which he or she has been provided a scholarship under such contract before the completion of such training; or

''(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract;

shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

''(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified

in subsection (l) of section 110 in the manner provided for in such subsection.

''(C) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Indian tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary deems appropriate.

''(6) REQUIRED AGREEMENTS.—The recipient of a scholarship under paragraph (1) shall agree, in providing health care pursuant to the requirements of this subsection—

''(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

''(B) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the

State agency that administers the State plan for medical assistance under title XIX of such Act to provide service to individuals entitled to medical assistance under the plan.

''(7) PAYMENTS.—The Secretary, through the area office, shall make payments under this subsection to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary or area office determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has not complied with the requirements of this subsection.

''SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

''(c) REQUIREMENTS.—

''(1) REGULATIONS.—The Secretary shall promulgate regulations pursuant to this Act for the competitive awarding of funds under this section.

''(2) PROGRAM.—Applicants for funds under this section shall agree to provide a program which, at a minimum—

''(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and accredited and accessible community colleges that will be served by the program;

''(B) incorporates a program advisory board comprised of representatives from the

tribes and communities that will be served by the program;

''(C) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(D) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(E) develops affiliation agreements with tribal community colleges, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

''(F) utilizes, to the maximum extent feasible, existing university tutoring, counseling and student support services; and

''(G) employs, to the maximum extent feasible, qualified Indians in the program.

''(d) ACTIVE DUTY OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

''(1) in the Indian Health Service;

''(2) in a program conducted under a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act;

''(3) in a program assisted under title V; or

''(4) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

''(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

''(b) ENROLLEES IN COURSE OF STUDY.—Any individual who is enrolled in a course of study in the health professions may be employed by the Service or by an In-

dian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(c) HIGH SCHOOL PROGRAMS.—Any individual who is in a high school program authorized under section 103(a) may be employed by the Service, or by a Indian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(d) ADMINISTRATIVE PROVISIONS.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

''In order to encourage health professionals, including for purposes of this section, community health representatives and emergency medical technicians, to join or continue in the Service or in any program of an Indian tribe, tribal organization, or urban Indian organization and to provide their services in the rural and remote areas where a significant portion of the Indian people reside, the Secretary, acting through the area offices, may provide allowances to health professionals employed in the Service or such a program to enable such professionals to take leave of their duty stations for a period of time each year (as prescribed by regulations of the Secretary) for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall maintain a Community Health Representative Program under which the Service, Indian tribes and tribal organizations—

''(1) provide for the training of Indians as community health representatives; and

''(2) use such community health representatives in the provision of health care, health promotion,

and disease prevention services to Indian communities.

''(b) ACTIVITIES.—The Secretary, acting through the Community Health Representative Program, shall—

''(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

''(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion,

and disease prevention and maintain programs that meet the needs for such continuing education;

''(4) maintain a system that provides close supervision of community health representatives;

''(5) maintain a system under which the work of community health representatives is reviewed and evaluated; and

''(6) promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

''(2) DEFINITIONS.—In this section:

''(A) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

''(i) directly by the Service;

''(ii) by any Indian tribe or tribal or Indian organization pursuant to a funding agreement under—

''(I) the Indian Self-Determination and Educational Assistance Act; or

''(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47) (commonly known as the 'Buy-Indian Act'); or

''(iii) by an urban Indian organization pursuant to title V.

''(B) STATE.—The term 'State' has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

''(b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—

''(1)(A) be enrolled—

''(i) in a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

''(ii) in an approved graduate training program in a health profession; or

''(B) have—

''(i) a degree in a health profession; and

''(ii) a license to practice a health profession in a State;

''(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

''(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

''(C) meet the professional standards for civil service employment in the Indian Health Service; or

''(D) be employed in an Indian health program without a service obligation; and

''(3) submit to the Secretary an application for a contract described in subsection (f).

''(c) FORMS.—

''(1) IN GENERAL.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health Service to enable the individual to make a decision on an informed basis.

''(2) FORMS TO BE UNDERSTANDABLE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

''(3) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other in-

formation available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) PRIORITY.—

''(1) ANNUAL DETERMINATIONS.—The Secretary, acting through the Service and in accordance with subsection (k), shall annually—

''(A) identify the positions in each Indian health program for which there is a need or a vacancy; and

''(B) rank those positions in order of priority.

''(2) PRIORITY IN APPROVAL.—Notwithstanding the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

''(A) give first priority to applications made by individual Indians; and

''(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

''(i) individuals recruited through the efforts an Indian tribe, tribal organization, or urban Indian organization; and

''(ii) other individuals based on the priority rankings under paragraph (1).

''(e) CONTRACTS.—

''(1) IN GENERAL.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

''(2) NOTICE.—Not later than 21 days after considering an individual for participation in the Loan Repayment Program under paragraph (1), the Secretary shall provide written notice to the individual of—

''(A) the Secretary's approving of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

''(B) the Secretary's disapproving an individual's participation in such Program.

''(f) WRITTEN CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(1) an agreement under which—

"(A) subject to paragraph (3), the Secretary agrees—

"(i) to pay loans on behalf of the individual in accordance with the provisions of this section; and

"(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

"(B) subject to paragraph (3), the individual agrees—

"(i) to accept loan payments on behalf of the individual;

"(ii) in the case of an individual described in subsection (b)(1)—

"(I) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

''(II) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);

''(iii) to serve for a time period (referred to in this section as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;

''(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iii);

''(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent

upon funds being appropriated for loan repayments under this section;

''(4) a statement of the damages to which the United States is entitled under subsection (l) for the individual's breach of the contract; and

''(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(g) LOAN REPAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

"(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

"(ii) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of

obligated service under the Loan Repayment Program.

''(B) TIME FOR PAYMENT.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made not later than the end of the fiscal year in which the individual completes such year of service.

''(3) SCHEDULE FOR PAYMENTS.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

''(h) COUNTING OF INDIVIDUALS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be counted against any employment ceiling affecting the Department.

''(i) RECRUITING PROGRAMS.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other health professional programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

''(j) NONAPPLICATION OF CERTAIN PROVISION.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian health programs pursuant to contracts entered into under this section, shall—

''(1) ensure that the staffing needs of Indian health programs administered by an Indian tribe or tribal or health organization receive consideration on an equal basis with programs that are administered directly by the Service; and

''(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(l) BREACH OF CONTRACT.—

''(1) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

''(A) is enrolled in the final year of a course of study and who—

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) voluntarily terminates such enrollment; or

"(iii) is dismissed from such educational institution before completion of such course of study; or

"(B) is enrolled in a graduate training program, and who fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

"(2) AMOUNT OF RECOVERY.—If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to re-

cover from such individual an amount to be determined in accordance with the following formula:

$$A=3Z(t-s/t)$$

in which—

"(A) 'A' is the amount the United States is entitled to recover;

"(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

"(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

"(D) 's' is the number of months of such period served by such individual in accordance with this section.

Amounts not paid within such period shall be subject to collection through deductions in medicare payments pursuant to section 1892 of the Social Security Act.

"(3) DAMAGES.—

"(A) TIME FOR PAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach of contract or such longer period beginning on such date as shall be specified by the Secretary.

"(B) DELINQUENCIES.—If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

"(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

"(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

"(C) CONTRACTS FOR RECOVERY OF DAMAGES.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United

States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

''(m) CANCELLATION, WAIVER OR RELEASE.—

''(1) CANCELLATION.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

''(2) WAIVER OF SERVICE OBLIGATION.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

''(3) WAIVER OF RIGHTS OF UNITED STATES.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

''(4) RELEASE.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bank-

ruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

''(n) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to the Congress under section 801, a report concerning the previous fiscal year which sets forth—

''(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

''(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

''(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

''(4) the amount of loan payments made under this section, in total and by health profession;

''(5) the number of scholarship grants that are provided under section 105 with respect to each health profession;

''(6) the amount of scholarship grants provided under section 105, in total and by health profession;

''(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the 3 fiscal years beginning after the date the report is filed; and

''(8) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes, tribal organizations, or urban Indian organizations for which recruitment or retention is difficult.

''SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

''(a) ESTABLISHMENT.—Notwithstanding section 102, there is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

''(1) such amounts as may be collected from individuals under subparagraphs (A) and (B) of section 105(b)(4) and section 110(l) for breach of contract;

''(2) such funds as may be appropriated to the LRRF;

''(3) such interest earned on amounts in the LRRF; and

''(4) such additional amounts as may be collected, appropriated, or earned relative to the LRRF.

Amounts appropriated to the LRRF shall remain available until expended.

''(b) USE OF LRRF.—

''(1) IN GENERAL.—Amounts in the LRRF may be expended by the Secretary, subject to section 102, acting through the Service, to make payments to the Service or to an Indian tribe or tribal organization administering a health care program pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act—

''(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to meet the obligated service requirements pursuant to sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached

the contract entered into under section 105 or section 110.

''(2) SCHOLARSHIPS AND RECRUITING.—An Indian tribe or tribal organization receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or to recruit and employ, directly or by contract, health professionals to provide health care services.

''(c) INVESTING OF FUND.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE PRICE.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

''SEC. 112. RECRUITMENT ACTIVITIES.

''(a) REIMBURSEMENT OF EXPENSES.—The Secretary may reimburse health professionals seeking positions in the Service, Indian tribes, tribal organizations, or

urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

''(b) ASSIGNMENT OF PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each area office to be responsible on a full-time basis for recruitment activities.

''SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

''(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 110(a)(2)(A)).

''(b) ELIGIBILITY.—Any Indian tribe, tribal organization, or urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

''(a) DEMONSTRATION PROJECT.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian health program (as defined in section 110) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

''(b) SERVICE OBLIGATION.—

''(1) IN GENERAL.—An individual who participates in the project under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such project.

''(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula speci-

fied in subsection (l) of section 110 in the manner provided for in such subsection.

''(c) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

''SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

''(a) GRANTS.—Notwithstanding section 102, the Secretary, acting through the Service, shall provide funds to—

''(1) public or private schools of nursing;

''(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

''(3) nurse midwife programs, and advance practice nurse programs, that are provided by any tribal college accredited nursing program, or in the absence of such, any other public or private institution,

for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

''(b) USE OF GRANTS.—Funds provided under subsection (a) may be used to—

''(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses;

''(2) provide scholarships to Indian individuals enrolled in such programs that may be used to pay the tuition charged for such program and for other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses;

''(3) provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians;

''(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses; or

''(5) provide any program that is designed to achieve the purpose described in subsection (a).

''(c) APPLICATIONS.—Each application for funds under subsection (a) shall include such information as the

Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

''(d) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

''(1) programs that provide a preference to Indians;

''(2) programs that train nurse midwives or advanced practice nurses;

''(3) programs that are interdisciplinary; and

''(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 5324(a) of the Indian Education Act of 1988.

''(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

''(f) SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded under subsection (a). Such obligation shall be met by service—

''(1) in the Indian Health Service;

''(2) in a program conducted under a contract entered into under the Indian Self-Determination and Education Assistance Act;

''(3) in a program assisted under title V; or

''(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''SEC. 116. TRIBAL CULTURE AND HISTORY.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian tribes in each service area receive educational instruction in the history and culture of such tribes and their relationship to the Service.

''(b) REQUIREMENTS.—To the extent feasible, the educational instruction to be provided under subsection (a) shall—

''(1) be provided in consultation with the affected tribal governments, tribal organizations, and urban Indian organizations;

''(2) be provided through tribally-controlled community colleges (within the meaning of section 2(4) of the Tribally Controlled Community College Assistance Act of 1978) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

''(3) include instruction in Native American studies.

''SEC. 117. INMED PROGRAM.

''(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

''(b) QUENTIN N. BURDICK INDIAN HEALTH PROGRAM.—The Secretary shall provide 1 of the grants under

subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall develop regulations to govern grants under to this section.

''(2) PROGRAM REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program that—

''(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community colleges located on Indian reservations which will be served by the program;

''(B) incorporates a program advisory board comprised of representatives from the tribes and communities which will be served by the program;

''(C) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

''(D) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university; and

''(E) to the maximum extent feasible, employs qualified Indians in the program.

''SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

''(a) ESTABLISHMENT GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

''(2) AMOUNT.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is pro-

vided to the community college shall not exceed $100,000.

''(b) CONTINUATION GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

''(2) ELIGIBILITY.—Grants may only be made under this subsection to a community college that—

''(A) is accredited;

''(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

''(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

''(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal health programs;

''(D) has a qualified staff which has the appropriate certifications;

''(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs, and

''(2) providing technical assistance and support to such colleges.

''(d) SPECIFIED COURSES OF STUDY.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses

of study which provide advanced training for any health professional who—

''(1) has already received a degree or diploma in such health profession; and

''(2) provides clinical services on an Indian reservation, at a Service facility, or at a tribal clinic.

Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

''(e) PRIORITY.—Priority shall be provided under this section to tribally controlled colleges in service areas that meet the requirements of subsection (b).

''(f) DEFINITIONS.—In this section:

''(1) COMMUNITY COLLEGE.—The term 'community college' means—

''(A) a tribally controlled community college; or

''(B) a junior or community college.

''(2) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college' has the meaning given such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(3) TRIBALLY CONTROLLED COLLEGE.—The term 'tribally controlled college' has the meaning

given the term 'tribally controlled community college' by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

"SEC. 119. RETENTION BONUS.

''(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

''(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

''(2) the Secretary determines is needed by the Service, tribe, tribal organization, or urban organization;

''(3) has—

''(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban organization; or

''(B) completed any service obligations incurred as a requirement of—

''(i) any Federal scholarship program; or

''(ii) any Federal education loan repayment program; and

''(4) enters into an agreement with the Service, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

''(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

''(c) FAILURE TO COMPLETE TERM OF SERVICE.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(l)(2)(B).

''(d) FUNDING AGREEMENT.—The Secretary may pay a retention bonus to any health professional employed by an organization providing health care services to Indians pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act if such

health professional is serving in a position which the Secretary determines is—

''(1) a position for which recruitment or retention is difficult; and

''(2) necessary for providing health care services to Indians.

''SEC. 120. NURSING RESIDENCY PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

''(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degree in nursing and public health.

''(c) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an

obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; commonly known as the Snyder Act), the Secretary shall maintain a Community Health Aide Program in Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

''(b) ACTIVITIES.—The Secretary, acting through the Community Health Aide Program under subsection (a), shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objective specified in section 3(b);

''(3) establish and maintain a Community Health Aide Certification Board to certify as com-

munity health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or who can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

''Subject to Section 102, the Secretary, acting through the Service, shall, through a funding agreement or otherwise, provide training for Indians in the administration and planning of tribal health programs.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT.

''(a) PILOT PROGRAMS.—The Secretary may, through area offices, fund pilot programs for tribes and tribal organizations to address chronic shortages of health professionals.

''(b) PURPOSE.—It is the purpose of the health professions demonstration project under this section to—

''(1) provide direct clinical and practical experience in a service area to health professions students and residents from medical schools;

''(2) improve the quality of health care for Indians by assuring access to qualified health care professionals; and

''(3) provide academic and scholarly opportunities for health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

''(c) ADVISORY BOARD.—A pilot program established under subsection (a) shall incorporate a program advisory board that shall be composed of representatives from the tribes and communities in the service area that will be served by the program.

"SEC. 124. SCHOLARSHIPS.

''Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'quali-

fied scholarships' for purposes of section 117 of the Internal Revenue Code of 1986.

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

''(a) LIMITATIONS.—The Secretary shall not—

''(1) remove a member of the National Health Services Corps from a health program operated by Indian Health Service or by a tribe or tribal organization under a funding agreement with the Service under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations; or

''(2) withdraw the funding used to support such a member;

unless the Secretary, acting through the Service, tribes or tribal organization, has ensured that the Indians receiving services from such member will experience no reduction in services.

''(b) DESIGNATION OF SERVICE AREAS AS HEALTH PROFESSIONAL SHORTAGE AREAS.—All service areas served by programs operated by the Service or by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization, shall be designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) as Health Professional Shortage Areas.

''(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify for the commissioned corps in the Public Health Service shall be exempt from the full time equivalent limitations of the National Health Service Corps and the Service when such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

''SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

''(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

''(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

''(c) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period

of 1 year. Such contract or grant may be renewed for an additional 1 year period upon the approval of the Secretary.

''(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

''(e) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

''(f) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

''(g) DEFINITIONS.—In this section:

''(1) EDUCATIONAL CURRICULUM.—The term 'educational curriculum' means 1 or more of the following:

''(A) Classroom education.

''(B) Clinical work experience.

''(C) Continuing education workshops.

''(2) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' has the meaning given such term in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

''(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

''SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION.

''(a) STUDY AND LIST.—

''(1) IN GENERAL.—The Secretary and the Secretary of the Interior in consultation with Indian tribes and tribal organizations shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications in-

clude or should include, training in the identification, prevention, education, referral or treatment of mental illness, dysfunctional or self-destructive behavior.

''(2) POSITIONS.—The positions referred to in paragraph (1) are—

''(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(i) elementary and secondary education;

''(ii) social services, family and child welfare;

''(iii) law enforcement and judicial services; and

''(iv) alcohol and substance abuse;

''(B) staff positions within the Service; and

''(C) staff positions similar to those specified in subsection (b) and established and maintained by Indian tribes, tribal organizations, and urban Indian organizations, including positions established pursuant to funding agreements under the Indian Self-determination and Education Assistance Act, and this Act.

''(3) TRAINING CRITERIA.—

''(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position specified in subsection (b)(1) and ensure that appropriate training has been or will be provided to any individual in any such position.

''(B) TRAINING.—With respect to any such individual in a position specified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training or provide funds to an Indian tribe, tribal organization, or urban Indian organization for the training of appropriate individuals. In the case of a funding agreement, the appropriate Secretary shall ensure that such training costs are included in the funding agreement, if necessary.

''(4) CULTURAL RELEVANCY.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(5) COMMUNITY EDUCATION.—

''(A) DEVELOPMENT.—The Service shall develop and implement, or on request of an Indian tribe or tribal organization, assist an In-

dian tribe or tribal organization, in developing and implementing a program of community education on mental illness.

''(B) TECHNICAL ASSISTANCE.—In carrying out this paragraph, the Service shall, upon the request of an Indian tribe or tribal organization, provide technical assistance to the Indian tribe or tribal organization to obtain and develop community educational materials on the identification, prevention, referral and treatment of mental illness, dysfunctional and self-destructive behavior.

''(b) STAFFING.—

''(1) IN GENERAL.—Not later than 90 days after the date of enactment of the Act, the Director of the Service shall develop a plan under which the Service will increase the number of health care staff that are providing mental health services by at least 500 positions within 5 years after such date of enactment, with at least 200 of such positions devoted to child, adolescent, and family services. The allocation of such positions shall be subject to the provisions of section 102(a).

''(2) IMPLEMENTATION.—The plan developed under paragraph (1) shall be implemented under the

Act of November 2, 1921 (25 U.S.C. 13) (commonly know as the 'Snyder Act').

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) IN GENERAL.—The Secretary may expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, that are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in the health status and resources of all Indian tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with

respect to those Indian tribes with the highest levels of health status and resource deficiencies:

''(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

''(B) preventive health, including mammography and other cancer screening in accordance with section 207;

''(C) dental care;

''(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners;

''(E) emergency medical services;

''(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

''(G) accident prevention programs;

''(H) home health care;

''(I) community health representatives;

''(J) maintenance and repair; and

''(K) traditional health care practices.

''(b) USE OF FUNDS.—

''(1) LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act, the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

''(2) ALLOCATION.—

''(A) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to service units or Indian tribes or tribal organizations. The funds allocated to each tribe, tribal organization, or service unit under this subparagraph shall be used to improve the health status and reduce the resource deficiency of each tribe served by such service unit, tribe or tribal organization. Such allocation shall weigh the amounts appropriated in favor of those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians for all service areas, except that amounts allocated to each such area

using such a weighted allocation formula shall not be less than the amounts allocated to each such area in the previous fiscal year.

''(B) APPORTIONMENT.—The apportionment of funds allocated to a service unit, tribe or tribal organization under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes in accordance with this section and such rules as may be established under title VIII.

''(c) HEALTH STATUS AND RESOURCE DEFICIENCY.—In this section:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objective set forth in section 3(2) is not being achieved; and

''(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) RESOURCES.—The health resources available to an Indian tribe or tribal organization shall include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) REVIEW OF DETERMINATION.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such tribe or tribal organization.

''(d) ELIGIBILITY.—Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health status and resource deficiency report of the Service for each

Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity;

''(B) the number of Indians eligible for health services in each service unit or Indian tribe or tribal organization; and

''(C) the number of Indians using the Service resources made available to each service unit or Indian tribe or tribal organization, and,

to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(f) BUDGETARY RULE.—Funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

''(h) DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is hereby established an Indian Catastrophic Health Emergency Fund (referred to in this section as the 'CHEF') consisting of—

''(A) the amounts deposited under subsection (d); and

''(B) any amounts appropriated to the CHEF under this Act.

''(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(3) EQUITABLE ALLOCATION.—The CHEF shall be equitably allocated, apportioned or delegated on a service unit or area office basis, based upon a formula to be developed by the Secretary in consultation with the Indian tribes and tribal organizations through negotiated rulemaking under title VIII. Such formula shall take into account the added needs of service areas which are contract health service dependent.

''(4) NOT SUBJECT TO CONTRACT OR GRANT.—No part of the CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

''(5) ADMINISTRATION.—Amounts provided from the CHEF shall be administered by the area offices based upon priorities determined by the In-

dian tribes and tribal organizations within each service area, including a consideration of the needs of Indian tribes and tribal organizations which are contract health service-dependent.

''(b) REQUIREMENTS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the CHEF;

''(2) provide that a service unit, Indian tribe, or tribal organization shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treatment for any victim of such a catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) for 1999, not less than $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United

States city average) for the 12-month period ending with December of the previous year;

''(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

''(A) service units, Indian tribes, or tribal organizations, or facilities of the Service; or

''(B) non-Service facilities or providers whenever otherwise authorized by the Service;

in rendering treatment that exceeds threshold cost described in paragraph (2);

''(4) establish a procedure for payment from the CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

''(5) establish a procedure that will ensure that no payment shall be made from the CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

''(c) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the author-

ity of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act) or any other law.

''(d) DEPOSITS.—There shall be deposited into the CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from the CHEF.

''SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

''(a) FINDINGS.—Congress finds that health promotion and disease prevention activities will—

''(1) improve the health and well-being of Indians; and

''(2) reduce the expenses for health care of Indians.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

''(c) DISEASE PREVENTION AND HEALTH PROMOTION.—In this section:

''(1) DISEASE PREVENTION.—The term 'disease prevention' means the reduction, limitation, and pre-

vention of disease and its complications, and the reduction in the consequences of such diseases, including—

''(A) controlling—

''(i) diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

''(i) for the fluoridation of water; and

''(ii) immunizations.

''(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, environmental, and personal factors conducive to health, including—

''(A) raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in conformity with physical and mental capacity;

''(D) making available suitable housing, safe water, and sanitary facilities;

''(E) improving the physical economic, cultural, psychological, and social environment;

''(F) promoting adequate opportunity for spiritual, religious, and traditional practices; and

''(G) adequate and appropriate programs including—

''(i) abuse prevention (mental and physical);

''(ii) community health;

''(iii) community safety;

''(iv) consumer health education;

''(v) diet and nutrition;

''(vi) disease prevention (communicable, immunizations, HIV/AIDS);

''(vii) environmental health;

''(viii) exercise and physical fitness;

''(ix) fetal alcohol disorders;

''(x) first aid and CPR education;

''(xi) human growth and development;

''(xii) injury prevention and personal safety;

''(xiii) mental health (emotional, self-worth);

''(xiv) personal health and wellness practices;

''(xv) personal capacity building;

''(xvi) prenatal, pregnancy, and infant care;

''(xvii) psychological well being;

''(xiii) reproductive health (family planning);

''(xix) safe and adequate water;

''(xx) safe housing;

''(xxi) safe work environments;

''(xxii) stress control;

''(xxiii) substance abuse;

''(xxiv) sanitary facilities;

''(xxv) tobacco use cessation and reduction;

''(xxvi) violence prevention; and

''(xxvii) such other activities identified by the Service, an Indian tribe or tribal or-

ganization, to promote the achievement of the objective described in section 3(b).

''(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 801 an evaluation of—

''(1) the health promotion and disease prevention needs of Indians;

''(2) the health promotion and disease prevention activities which would best meet such needs;

''(3) the internal capacity of the Service to meet such needs; and

''(4) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

''SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

''(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types

of complications resulting from, diabetes among Indians; and

''(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

''(b) SCREENING.—The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by an Indian tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

''(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2015, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs operated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with

tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

''(d) DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

''(e) OTHER ACTIVITIES.—The Secretary shall, to the extent funding is available—

''(1) in each area office of the Service, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

''(2) establish in each area office of the Service a registry of patients with diabetes to track the prevalence of diabetes and the complications from diabetes in that area; and

''(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to tribes, tribal organizations, and all other area offices.

''SEC. 205. SHARED SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into funding agreements or

other arrangements with Indian tribes or tribal organizations for the delivery of long-term care and similar services to Indians. Such projects shall provide for the sharing of staff or other services between a Service or tribal facility and a long-term care or other similar facility owned and operated (directly or through a funding agreement) by such Indian tribe or tribal organization.

''(b) REQUIREMENTS.—A funding agreement or other arrangement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal facility be allocated proportionately between the Service and the tribe or tribal organization; and

''(3) may authorize such tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(d) USE OF EXISTING FACILITIES.—The Secretary shall encourage the use for long-term or similar care of existing facilities that are under-utilized or allow the use of swing beds for such purposes.

''SEC. 206. HEALTH SERVICES RESEARCH.

''(a) FUNDING.—The Secretary shall make funding available for research to further the performance of the health service responsibilities of the Service, Indian tribes, and tribal organizations and shall coordinate the activities of other Agencies within the Department to address these research needs.

''(b) ALLOCATION.—Funding under subsection (a) shall be allocated equitably among the area offices. Each area office shall award such funds competitively within that area.

''(c) ELIGIBILITY FOR FUNDS.—Indian tribes and tribal organizations receiving funding from the Service under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

''(d) USE.—Funds received under this section may be used for both clinical and non-clinical research by Indian tribes and tribal organizations and shall be distributed to the area offices. Such area offices may make grants using such funds within each area.

''SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

''The Secretary, through the Service or through Indian tribes or tribal organizations, shall provide for the following screening:

''(1) Mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act.

''(2) Other cancer screening meeting national standards.

''SEC. 208. PATIENT TRAVEL COSTS.

''The Secretary, acting through the Service, Indian tribes and tribal organizations shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving

health care services provided (either through direct or contract care or through funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act) under this Act:

''(1) Emergency air transportation and non-emergency air transportation where ground transportation is infeasible.

''(2) Transportation by private vehicle, specially equipped vehicle and ambulance.

''(3) Transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

''SEC. 209. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agreements under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sen-

tence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

''(2) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

''(A) collect data related to the health status objective described in section 3(b), and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

''(B) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(C) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

''(D) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

''(E) make recommendations to improve health care delivery systems for Indians and urban Indians;

''(F) provide requested technical assistance to Indian tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(G) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

''(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

''(b) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide funding to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and urban Indian children.

"(b) USE OF FUNDS.—Funds awarded under this section may be used to—

"(1) develop and implement health education curricula both for regular school programs and after school programs;

"(2) train teachers in comprehensive school health education curricula;

"(3) integrate school-based, community-based, and other public and private health promotion efforts;

"(4) encourage healthy, tobacco-free school environments;

"(5) coordinate school-based health programs with existing services and programs available in the community;

"(6) develop school programs on nutrition education, personal health, oral health, and fitness;

"(7) develop mental health wellness programs;

''(8) develop chronic disease prevention programs;

''(9) develop substance abuse prevention programs;

''(10) develop injury prevention and safety education programs;

''(11) develop activities for the prevention and control of communicable diseases;

''(12) develop community and environmental health education programs that include traditional health care practitioners;

''(13) carry out violence prevention activities; and

''(14) carry out activities relating to such other health issues as are appropriate.

''(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes, tribal organizations and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

''(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian orga-

nizations shall establish criteria for the review and approval of applications for funding under this section.

''(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

''(1) DEVELOPMENT.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary and affected Indian tribes and tribal organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 for use in schools operated by the Bureau of Indian Affairs.

''(2) REQUIREMENTS.—The program developed under paragraph (1) shall include—

''(A) school programs on nutrition education, personal health, oral health, and fitness;

''(B) mental health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

''(E) injury prevention and safety education programs; and

''(F) activities for the prevention and control of communicable diseases.

''(3) TRAINING AND COORDINATION.—The Secretary of the Interior shall—

''(A) provide training to teachers in comprehensive school health education curricula;

''(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

''(C) encourage healthy, tobacco-free school environments.

''SEC. 211. INDIAN YOUTH PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—Funds made available under this section may be used to—

''(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

''(B) develop and provide community training and education.

''(2) LIMITATION.—Funds made available under this section may not be used to provide services described in section 707(c).

''(c) REQUIREMENTS.—The Secretary shall—

''(1) disseminate to Indian tribes, tribal organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

''(2) encourage the implementation of such models; and

''(3) at the request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance in the implementation of such models.

''(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organization, and urban Indian organizations, shall establish criteria for the review and approval of applications under this section.

''SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Service after consultation with Indian tribes, tribal organizations, urban Indian organizations, and the Centers

for Disease Control and Prevention, may make funding available to Indian tribes and tribal organizations for—

''(1) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori, which projects may include screening, testing and treatment for HCV and other infectious and communicable diseases;

''(2) public information and education programs for the prevention, control, and elimination of communicable and infectious diseases;

''(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals; and

''(4) a demonstration project that studies the seroprevalence of the Hepatitis C virus among a random sample of American Indian and Alaskan Native populations and identifies prevalence rates among a variety of tribes and geographic regions.

''(b) REQUIREMENT OF APPLICATION.—The Secretary may provide funds under subsection (a) only if an application or proposal for such funds is submitted.

''(c) TECHNICAL ASSISTANCE AND REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

''(2) shall prepare and submit, biennially, a report to Congress on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.

''SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objective set forth in section 3 through health care related services and programs not otherwise described in this Act. Such services and programs shall include services and programs related to—

''(1) hospice care and assisted living;

''(2) long-term health care;

''(3) home- and community-based services;

''(4) public health functions; and

''(5) traditional health care practices.

''(b) AVAILABILITY OF SERVICES FOR CERTAIN INDIVIDUALS.—At the discretion of the Service, Indian tribe, or tribal organization, services hospice care, home health care (under section 201), home- and community-based care, assisted living, and long term care may be provided (on a cost basis) to individuals otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to a tribe or tribal organization.

''(c) DEFINITIONS.—In this section:

''(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 or more of the following:

''(A) Homemaker/home health aide services.

''(B) Chore services.

''(C) Personal care services.

''(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

''(E) Training for family members.

''(F) Adult day care.

''(G) Such other home- and community-based services as the Secretary or a tribe or tribal organization may approve.

''(2) HOSPICE CARE.—The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of such care.

''(3) PUBLIC HEALTH FUNCTIONS.—The term 'public health functions' means public health related programs, functions, and services including assessments, assurances, and policy development that Indian tribes and tribal organizations are authorized and encouraged, in those circumstances where it meets their needs, to carry out by forming collaborative relationships with all levels of local, State, and Federal governments.

''SEC. 214. INDIAN WOMEN'S HEALTH CARE.

''The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

"(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and tribal organizations, conduct a study and carry out ongoing monitoring programs to determine the trends that exist in the health hazards posed to Indian miners and to Indians on or near Indian reservations and in Indian communities as a result of environmental hazards that may result in chronic or life-threatening health problems. Such hazards include nuclear resource development, petroleum contamination, and contamination of the water source or of the food chain. Such study (and any reports with respect to such study) shall include—

"(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

"(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities including the cumulative effect of such development over time on health;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal, oil and gas production or transportation on or near Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

"(4) a summary of any findings or recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of this Act that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) a description of the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

"(b) DEVELOPMENT OF HEALTH CARE PLANS.—Upon the completion of the study under subsection (a),

the Secretary and the Service shall take into account the results of such study and, in consultation with Indian tribes and tribal organizations, develop a health care plan to address the health problems that were the subject of such study. The plans shall include—

''(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

''(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION TO CONGRESS.—

''(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress a report concerning the study conducted under subsection (a).

''(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address the health problems involved.

''(d) TASK FORCE.—

''(1) ESTABLISHED.—There is hereby established an Intergovernmental Task Force (referred to in this section as the 'task force') that shall be composed of the following individuals (or their designees):

''(A) The Secretary of Energy.

''(B) The Administrator of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(2) DUTIES.—The Task Force shall identify existing and potential operations related to nuclear resource development or other environmental haz-

ards that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community, and enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

''(3) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

''(e) PROVISION OF APPROPRIATE MEDICAL CARE.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from a Service facility; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard;

the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

''SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2015, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 216A. NORTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of North Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of North Dakota.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of North Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 216B. SOUTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of South Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of South Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

''SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—The Secretary may fund a program that utilizes the California Rural Indian Health Board as a contract care intermediary to improve the accessibility of health services to California Indians.

''(b) REIMBURSEMENT OF BOARD.—

''(1) AGREEMENT.—The Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

''(2) ADMINISTRATION.—Not more than 5 percent of the amounts provided to the Board under

this section for any fiscal year may be used for reimbursement for administrative expenses incurred by the Board during such fiscal year.

''(3) LIMITATION.—No payment may be made for treatment provided under this section to the extent that payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

''(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

''SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San

Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State, except that any of the counties described in this section may be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

''SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

''The Service shall provide funds for health care programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

''Health care professionals employed by Indian tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

''With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

"(a) REQUIREMENT.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

"(b) FAILURE TO RESPOND.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

"(c) PAYMENT.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

"(a) NO LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

"(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services.

"(c) LIMITATION.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall

have no further recourse against the patient who received the services involved.

''SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE III—FACILITIES

''SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

''(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

''(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

''(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later

than 1 year after the date on which the construction or renovation of such facility is completed.

''(b) CLOSURE OF FACILITIES.—

''(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

''(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

''(B) the cost effectiveness of such closure;

''(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

''(D) the availability of contract health care funds to maintain existing levels of service;

''(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

''(F) the level of utilization of such hospital or facility by all eligible Indians; and

''(G) the distance between such hospital or facility and the nearest operating Service hospital.

''(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

''(c) PRIORITY SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a health care facility priority system, that shall—

''(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking under section 802;

''(B) give the needs of Indian tribes the highest priority, with additional priority being given to those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians in all service areas; and

''(C) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E);

except that the priority of any project established under the construction priority system in effect on the date of this Act shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as one of the top 10 priority inpatient projects or one of the top 10 outpatient projects in the Indian Health Service budget justification for fiscal year 2003, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of this Act.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report that includes—

''(A) a description of the health care facility priority system of the Service, as established under paragraph (1);

''(B) health care facility lists, including—

''(i) the total health care facility planning, design, construction and renovation needs for Indians;

''(ii) the 10 top-priority inpatient care facilities;

''(iii) the 10 top-priority outpatient care facilities;

''(iv) the 10 top-priority specialized care facilities (such as long-term care and alcohol and drug abuse treatment); and

''(v) any staff quarters associated with such prioritized facilities;

''(C) the justification for the order of priority among facilities;

''(D) the projected cost of the projects involved; and

''(E) the methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

''(A) consult with, and obtain information on all health care facilities needs from, Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the

Indian Self-Determination and Education Assistance Act; and

''(B) review the total unmet needs of all tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

''(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(5) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities, operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the health care facility priority system.

''(d) REVIEW OF NEED FOR FACILITIES.—

''(1) REPORT.—Beginning in 2004, the Secretary shall annually submit to the President, for in-

clusion in the report required to be transmitted to Congress under section 801 of this Act, a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities.

''(2) CONSULTATION.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

''(3) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(4) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.

''(5) ANNUAL NOMINATIONS.—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the health care facility priority system.

''(e) INCLUSION OF CERTAIN PROGRAMS.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

''(f) INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those

provided for in other sections of this title and other approaches.

"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

''(a) FINDINGS.—Congress finds and declares that—

''(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal facilities is primarily a health consideration and function;

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

''(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

''(4) many Indian homes and communities still lack safe water supply facilities and sanitary sewage and solid waste disposal facilities; and

''(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water sup-

ply facilities and sanitary sewage waste disposal facilities as soon as possible.

''(b) PROVISION OF FACILITIES AND SERVICES.—

''(1) IN GENERAL.—In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

''(2) ASSISTANCE.—The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

''(A) financial and technical assistance to Indian tribes, tribal organizations and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

''(B) ongoing technical assistance and training in the management of utility organiza-

tions which operate and maintain sanitation facilities; and

''(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

''(3) PROVISIONS RELATING TO FUNDING.—Notwithstanding any other provision of law—

''(A) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

''(B) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

"(D) the Secretary of Health and Human Services is authorized to accept all Federal funds that are available for the purpose of providing sanitation facilities and related services and place those funds into funding agreements, authorized under the Indian Self-Determination and Education Assistance Act, between the Secretary and Indian tribes and tribal organizations;

"(E) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to fund up to 100 percent of the amount of a tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

''(F) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

''(G) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned or appropriated and thereafter the Department's applicable policies, rules, regulations shall apply in the implementation of such projects;

''(H) the Secretary of Health and Human Services shall enter into inter-agency agreements with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

''(I) the Secretary of Health and Human Services shall, by regulation developed through

rulemaking under section 802, establish standards applicable to the planning, design and construction of water supply and sanitary sewage and solid waste disposal facilities funded under this Act.

''(c) 10-YEAR FUNDING PLAN.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, shall develop and implement a 10-year funding plan to provide safe water supply and sanitary sewage and solid waste disposal facilities serving existing Indian homes and communities, and to new and renovated Indian homes.

''(d) CAPABILITY OF TRIBE OR COMMUNITY.—The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(e) FINANCIAL ASSISTANCE.—The Secretary may provide financial assistance to Indian tribes, tribal organizations and communities for the operation, management, and maintenance of their sanitation facilities.

''(f) RESPONSIBILITY FOR FEES FOR OPERATION AND MAINTENANCE.—The Indian family, community or tribe involved shall have the primary responsibility to establish, collect, and use reasonable user fees, or otherwise

set aside funding, for the purpose of operating and maintaining sanitation facilities. If a community facility is threatened with imminent failure and there is a lack of tribal capacity to maintain the integrity or the health benefit of the facility, the Secretary may assist the tribe in the resolution of the problem on a short term basis through cooperation with the emergency coordinator or by providing operation and maintenance service.

''(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANIZATIONS.—Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

''(1) any funds appropriated pursuant to this section; and

''(2) any funds appropriated for the purpose of providing water supply, sewage disposal, or solid waste facilities;

on an equal basis with programs that are administered directly by the Service.

''(h) REPORT.—

''(1) IN GENERAL.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report which sets forth—

''(A) the current Indian sanitation facility priority system of the Service;

''(B) the methodology for determining sanitation deficiencies;

''(C) the level of initial and final sanitation deficiency for each type sanitation facility for each project of each Indian tribe or community; and

''(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian tribes and communities to a level I sanitation deficiency as described in paragraph (4)(A).

''(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

''(3) METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

''(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual or community sanitation facility serving Indian homes are as follows:

''(A) A level I deficiency is a sanitation facility serving an individual or community—

''(i) which complies with all applicable water supply, pollution control and solid waste disposal laws; and

''(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs.

''(B) A level II deficiency is a sanitation facility serving an individual or community—

''(i) which substantially or recently complied with all applicable water supply, pollution control and solid waste laws, in which the deficiencies relate to small or minor capital improvements needed to bring the facility back into compliance;

''(ii) in which the deficiencies relate to capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

''(iii) in which the deficiencies relate to the lack of equipment or training by an Indian tribe or community to properly operate and maintain the sanitation facilities.

''(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

''(D) A level IV deficiency is an individual or community facility where there are no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure or where only a washeteria or central facility exists.

''(E) A level V deficiency is the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater disposal.

''(i) DEFINITIONS.—In this section:

''(1) FACILITY.—The terms 'facility' or 'facilities' shall have the same meaning as the terms 'system' or 'systems' unless the context requires otherwise.

''(2) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

''SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

''(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water

and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

''(1) ownership and control by Indians;

''(2) equipment;

''(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

''(b) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall

be paid wages at rates that are not less than the prevailing wage rates for similar construction in the locality involved, as determined by the Indian tribe, tribes, or tribal organizations served by such facilities.

"SEC. 304. SOBOBA SANITATION FACILITIES.

"Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).

"SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to accept any major expansion, renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act, including—

"(A) any plans or designs for such expansion, renovation or modernization; and

''(B) any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended;

but only if the requirements of subsection (b) are met.

''(2) PRIORITY LIST.—The Secretary shall maintain a separate priority list to address the need for increased operating expenses, personnel or equipment for such facilities described in paragraph (1). The methodology for establishing priorities shall be developed by negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian tribes and tribal organizations.

''(3) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, the priority list maintained pursuant to paragraph (2).

''(b) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation or modernization if—

''(1) the tribe or tribal organization—

''(A) provides notice to the Secretary of its intent to expand, renovate or modernize; and

''(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel or equipment; and

''(2) the expansion renovation or modernization—

''(A) is approved by the appropriate area director of the Service for Federal facilities; and

''(B) is administered by the Indian tribe or tribal organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

''(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal

program that were expended for such expansion, renovation or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation or modernization.

"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

''(a) AVAILABILITY OF FUNDING.—

''(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

''(2) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or con-

structed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—Funds provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 307; and

''(C) which, upon completion of such construction, expansion, or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually not less than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B); and

''(iii) provide ambulatory care in a service area (specified in the funding agreement entered into under the Indian Self-Determination and Education Assistance Act) with a population of not less than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B).

''(2) LIMITATION.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion or modernization project that benefits the service population described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

''(c) APPLICATION AND PRIORITY.—

''(1) APPLICATION.—No funding may be made available under this section unless an application for such funding has been submitted to and approved by the Secretary. An application or proposal for fund-

ing under this section shall be submitted in accordance with applicable regulations and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

''(A) adequate financial support will be available for the provision of services at such facility;

''(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

''(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

''(2) PRIORITY.—In awarding funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

''(A) a need for increased ambulatory care services; and

''(B) insufficient capacity to deliver such services.

''(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof) with respect to

which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian tribe or tribal organization.

''(e) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

''SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

''(a) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, may enter into funding agreements with, or make grants or loan guarantees to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facili-

ties, including hospice, traditional Indian health and child care facilities, to Indians.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

''(1) waive any leasing prohibition;

''(2) permit carryover of funds appropriated for the provision of health care services;

''(3) permit the use of other available funds;

''(4) permit the use of funds or property donated from any source for project purposes;

''(5) provide for the reversion of donated real or personal property to the donor; and

''(6) permit the use of Service funds to match other funds, including Federal funds.

''(c) CRITERIA.—

''(1) IN GENERAL.—The Secretary shall develop and publish regulations through rulemaking under section 802 for the review and approval of applications submitted under this section. The Secretary may enter into a contract, funding agreement or award a grant under this section for projects which meet the following criteria:

''(A) There is a need for a new facility or program or the reorientation of an existing facility or program.

''(B) A significant number of Indians, including those with low health status, will be served by the project.

''(C) The project has the potential to address the health needs of Indians in an innovative manner.

''(D) The project has the potential to deliver services in an efficient and effective manner.

''(E) The project is economically viable.

''(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

''(G) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

''(2) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such ap-

plications using the criteria developed pursuant to paragraph (1).

''(3) PRIORITY.—The Secretary shall give priority to applications for demonstration projects under this section in each of the following service units to the extent that such applications are filed in a timely manner and otherwise meet the criteria specified in paragraph (1):

''(A) Cass Lake, Minnesota.

''(B) Clinton, Oklahoma.

''(C) Harlem, Montana.

''(D) Mescalero, New Mexico.

''(E) Owyhee, Nevada.

''(F) Parker, Arizona.

''(G) Schurz, Nevada.

''(H) Winnebago, Nebraska.

''(I) Ft. Yuma, California.

''(d) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(e) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-

Service health care practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

''(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

''SEC. 308. LAND TRANSFER.

''(a) GENERAL AUTHORITY FOR TRANSFERS.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost,

land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

''(b) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

''SEC. 309. LEASES.

''(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

''(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

''(1) title to;

''(2) a leasehold interest in; or

''(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

''SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAYMENT.

''(a) HEALTH CARE FACILITIES LOAN FUND.—There is established in the Treasury of the United States a fund to be known as the 'Health Care Facilities Loan Fund' (referred to in this Act as the 'HCFLF') to provide to Indian tribes and tribal organizations direct loans, or

guarantees for loans, for the construction of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities such as behavioral health and elder care facilities).

''(b) STANDARDS AND PROCEDURES.—The Secretary may promulgate regulations, developed through rulemaking as provided for in section 802, to establish standards and procedures for governing loans and loan guarantees under this section, subject to the following conditions:

''(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

''(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

''(3) In the discretion of the Secretary, the program under this section may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

''(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is less.

''(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

''(6) The Secretary may accept an assignment of the revenue of an Indian tribe or tribal organization as security for any direct loan or loan guarantee under this section.

''(7) In the planning and design of health facilities under this section, users eligible under section 807(b) may be included in any projection of patient population.

''(8) The Secretary shall not collect loan application, processing or other similar fees from Indian tribes or tribal organizations applying for direct loans or loan guarantees under this section.

''(9) Service funds authorized under loans or loan guarantees under this section may be used in matching other Federal funds.

''(c) FUNDING.—

''(1) IN GENERAL.—The HCFLF shall consist of—

''(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated under paragraph (2);

''(B) such amounts as may be collected from borrowers; and

''(C) all interest earned on amounts in the HCFLF.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

''(3) AVAILABILITY OF FUNDS.—Amounts appropriated, collected or earned relative to the HCFLF shall remain available until expended.

''(d) FUNDING AGREEMENTS.—Amounts in the HCFLF and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make loans under this section to an Indian tribe or tribal organization pursuant to a funding agreement entered

into under the Indian Self-Determination and Education Assistance Act.

''(e) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the HCFLF as such Secretary determines are not required to meet current withdrawals from the HCFLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the fund may be sold by the Secretary of the Treasury at the market price.

''(f) GRANTS.—The Secretary is authorized to establish a program to provide grants to Indian tribes and tribal organizations for the purpose of repaying all or part of any loan obtained by an Indian tribe or tribal organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

''SEC. 311. TRIBAL LEASING.

''Indian tribes and tribal organizations providing health care services pursuant to a funding agreement con-

tract entered into under the Indian Self-Determination and Education Assistance Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

''SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian tribes and tribal organizations to establish joint venture demonstration projects under which an Indian tribe or tribal organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

''(2) USE OF RESOURCES.—A tribe or tribal organization may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

''(3) ELIGIBILITY OF CERTAIN ENTITIES.—A tribe that has begun and substantially completed the

process of acquisition or construction of a health facility shall be eligible to establish a joint venture project with the Service using such health facility.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall enter into an arrangement under subsection (a)(1) with an Indian tribe or tribal organization only if—

''(A) the Secretary first determines that the Indian tribe or tribal organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in subsection (a)(1); and

''(B) the Indian tribe or tribal organization meets the needs criteria that shall be developed through the negotiated rulemaking process provided for under section 802.

''(2) CONTINUED OPERATION OF FACILITY.—The Secretary shall negotiate an agreement with the Indian tribe or tribal organization regarding the continued operation of a facility under this section at the end of the initial 10 year no-cost lease period.

''(3) BREACH OR TERMINATION OF AGREEMENT.—An Indian tribe or tribal organization that has entered into a written agreement with the Sec-

retary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe or tribal organization, or paid to a third party on the tribe's or tribal organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

''(d) RECOVERY FOR NON-USE.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility should at any time within 10 years the Service ceases to use the facility or otherwise breaches the agreement.

''(e) DEFINITION.—In this section, the terms 'health facility' or 'health facilities' include staff quarters needed to provide housing for the staff of the tribal health program.

"SEC. 313. LOCATION OF FACILITIES.

''(a) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

''(b) DEFINITION.—In this section, the term 'Indian lands' means—

''(1) all lands within the exterior boundaries of any Indian reservation;

''(2) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

''(3) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

"SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

''(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

''(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

''(1) IN GENERAL.—The Secretary may expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian tribe or tribal organization.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'supportable space allocation' shall be defined through the negotiated rulemaking process provided for under section 802.

''(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

''(1) IN GENERAL.—In addition to using maintenance and improvement funds for the maintenance

of facilities under subsection (b)(1), an Indian tribe or tribal organization may use such funds for the construction of a replacement facility if the costs of the renovation of such facility would exceed a maximum renovation cost threshold.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'maximum renovation cost threshold' shall be defined through the negotiated rulemaking process provided for under section 802.

''SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

''(a) ESTABLISHMENT OF RENTAL RATES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates under paragraph (1), an Indian tribe or tribal orga-

nization shall attempt to achieve the following objectives:

''(A) The rental rates should be based on the reasonable value of the quarters to the occupants thereof.

''(B) The rental rates should generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and, subject to the discretion of the Indian tribe or tribal organization, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other federally-owned quarters that are used to house personnel in Service-supported programs.

''(4) NOTICE OF CHANGE IN RATES.—An Indian tribe or tribal organization that exercises the authority provided under this subsection shall provide occupants with not less than 60 days notice of any change in rental rates.

''(b) COLLECTION OF RENTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), an Indian tribe or a tribal organization that operates federally-owned quarters pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

''(A) The Indian tribe or tribal organization shall notify the Secretary and the Federal employees involved of its election to exercise its authority to collect rents directly from such Federal employees.

''(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Indian tribe or tribal organization and shall not be made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

''(2) RETROCESSION.—If an Indian tribe or tribal organization which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally-owned quarters, such retrocession shall become effective on the earlier of—

''(A) the first day of the month that begins not less than 180 days after the Indian tribe or tribal organization notifies the Secretary of its desire to retrocede; or

''(B) such other date as may be mutually agreed upon by the Secretary and the Indian tribe or tribal organization.

''(c) RATES.—To the extent that an Indian tribe or tribal organization, pursuant to authority granted in subsection (a), establishes rental rates for federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rent-

al housing in the nearest established community with a year-round population of 1,500 or more individuals.

"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

"(a) IN GENERAL.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to the authorization contained in section 318, except that Indian tribes and tribal organizations shall be exempt from such requirements.

"(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

"(c) DEFINITION.—In this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office

Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 317. OTHER FUNDING FOR FACILITIES.

''Notwithstanding any other provision of law—

''(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

''(2) the Secretary may enter into interagency agreements with other Federal or State agencies and other entities and to accept funds from such Federal or State agencies or other entities to provide for the planning, design and construction of health care facilities to be administered by the Service or by Indian tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act in

order to carry out the purposes of this Act, together with the purposes for which such funds are appropriated to such other Federal or State agency or for which the funds were otherwise provided;

''(3) any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency; and

''(4) the Secretary, acting through the Service, shall establish standards under regulations developed through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

''SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

''(a) IN GENERAL.—Any payments received by the Service, by an Indian tribe or tribal organization pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization pursuant to title V of this Act for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

''(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

''(c) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such

amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

''(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

''SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

''(a) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally re-

tarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives 100 percent of the amounts to which the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

''(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal

organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

''(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

''SEC. 403. REPORT.

''(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

''(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

''SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

''(1) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

''(2) pay premiums for health insurance coverage; and

''(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

''(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

''(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

''(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

''(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

''(4) develop and implement—

''(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

''(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

''(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Fi-

nancing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

''(d) GRANTS.—

''(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

''(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

''(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

''(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

''(A) consistent with the conditions imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to carry out the purposes of this section.

''SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

''(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), under the medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or from any other third party payor.

''(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social

Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of reimbursement under title XIX of the Social Security Act for health care services directly billed under the program established under this section.

''(b) DIRECT REIMBURSEMENT.—

''(1) USE OF FUNDS.—Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under titles XVIII and XIX of the Social Security Act for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 402(a) and 807(b)(2)(A), but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under title XVIII or XIX of the Social Security Act. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—

''(A) solely for improving the health resources deficiency level of the Indian tribe; and

''(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

''(2) AUDITS.—The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act.

''(3) SECRETARIAL OVERSIGHT.—The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

''(4) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or

clinic participates in the program established under this section.

''(c) REQUIREMENTS FOR PARTICIPATION.—

''(1) APPLICATION.—Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—

''(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

''(B) the facility is eligible to participate in the medicare or medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);

''(C) the facility meets the requirements that apply to programs operated directly by the Service; and

''(D) the facility—

''(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

''(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

''(2) APPROVAL.—

''(A) IN GENERAL.—The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

''(B) GRANDFATHER OF DEMONSTRATION PROGRAM PARTICIPANTS.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 2000 shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

''(C) DURATION.—An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved

applicant or the deemed approved demonstration program meets the requirements of this section.

''(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—

''(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under title XIX of the Social Security Act; and

''(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

"(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 2000. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

"(e) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or an Indian tribe or tribal organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if—

''(1) such services had been provided by a nongovernmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such expenses.

''(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

''(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery provided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

''(f) METHODS OF ENFORCEMENT.—

''(1) IN GENERAL.—The United States or an Indian tribe or tribal organization may enforce the right of recovery provided under subsection (a), and an urban Indian organization may enforce the right of recovery provided under subsection (b), by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian tribe or tribal organization, or urban Indian organization; or

''(ii) by any representative or heirs of such individual; or

''(B) instituting a civil action.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of an action instituted in accordance with paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(g) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United

States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

''(h) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded reasonable attorneys' fees and costs of litigation.

''(i) RIGHT OF ACTION AGAINST INSURERS AND EMPLOYEE BENEFIT PLANS.—

''(1) IN GENERAL.—Where an insurance company or employee benefit plan fails or refuses to pay the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the United States or an Indian tribe or tribal organization shall have a right to assert and pursue all the claims and remedies against such company or plan,

and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

''(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

''(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA–1500 or UB–92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

"SEC. 407. CREDITING OF REIMBURSEMENTS.

''(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

''(b) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

''An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Secretary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

''(1) a tribally owned and operated managed care plan;

''(2) a State or locally-authorized or licensed managed care plan; or

''(3) a health insurance provider.

''SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

''(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

''(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

''(2) SUBMISSION OF REPORT.—Not later than September 30, 2003, the Secretary shall submit the report required under paragraph (1) to Congress.

''(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

"(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Service;

"(2) the quality of health care services provided to any Indian through the Service;

"(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

''(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

''SEC. 410. PAYOR OF LAST RESORT.

''The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

''SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS.

''Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

"(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

"(2) purchase insurance to limit the financial risks under the project.

"(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

"Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be enti-

tled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

''(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

''(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

''(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

''(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

''(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

''SEC. 415. LIMITATIONS ON CHARGES.

''No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any federally funded (whether in whole or part) health care program may seek to recover payment for services—

''(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

''(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

"Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers

health programs under the authority of the Indian Self-Determination and Education Assistance Act;

''(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

''(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2003); or

''(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization;

provided the exchange arises from or relates to such health programs.

''(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act

or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an Indian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an In-

dian tribe or tribal organization or an urban Indian organization and another health provider.

''(b) EXEMPTION FROM PREMIUMS.—

''(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX or XXI of such Act.

''(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

''For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

''Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

''(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

''(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

''(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

''(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

''SEC. 422. MEDICAL CHILD SUPPORT.

''Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization. For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

''SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

''(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization or an urban Indian organization shall have a right of recovery under section

408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian tribe or tribal organization or an urban Indian organization.

''(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement may not be made a prerequisite for such payments to be made.

''(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

''(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

''(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

''(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

''(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under

any managed care entity participating in a State plan under title XIX or XXI of the Social Security Act unless the Indian had the option of enrolling in a managed care plan or health program administered by the Service, an Indian tribe or tribal organization, or an urban Indian organization.

''(h) INDIAN MANAGED CARE PLANS.—Notwithstanding any other provision of law, any State entering into agreements with one or more managed care organizations to provide services under title XIX or XXI of the Social Security Act shall enter into such an agreement with the Service, an Indian tribe or tribal organization or an urban Indian organization under which such an entity may provide services to Indians who may be eligible or required to enroll with a managed care organization through enrollment in an Indian managed care organization that provides services similar to those offered by other managed care organizations in the State. The Secretary and the State are hereby authorized to waive requirements regarding discrimination, capitalization, and other matters that might otherwise prevent an Indian managed care organization or health program from meeting Federal or State standards applicable to such organizations, provided such Indian managed care organization or health program

offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

''(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

''SEC. 424. NAVAJO NATION MEDICAID AGENCY.

''(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

''(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

''(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

''(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

''(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

''(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

''(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

''SEC. 425. INDIAN ADVISORY COMMITTEES.

''(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

''(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the

Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

''SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title.''.

''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

''SEC. 501. PURPOSE.

''The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

''SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include

such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

''(a) AUTHORITY.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

''(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

''(2) estimate the current health status of urban Indians residing in such urban center or centers;

''(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

''(4) provide basic health education, including health promotion and disease prevention education, to urban Indians;

''(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

''(6) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

''(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of urban Indians in the urban center or centers involved;

''(2) the size of the urban Indian population in the urban center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

''(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

''(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

''(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

''(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or pro-

vide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

''(2) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) MENTAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

''(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

''(3) USE OF FUNDS.—Grants may be made under this subsection—

''(A) to prepare assessments required under paragraph (2);

''(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct behavioral health services, to educate urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to urban Indians;

''(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment; and

''(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) CHILD ABUSE.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts

entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

''(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) USE OF FUNDS.—Grants may be made under this subsection—

''(A) to prepare assessments required under paragraph (2);

''(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

''(C) to provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

''(4) CONSIDERATIONS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

''(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

''(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

''(C) the assessment required under paragraph (2).

''(g) MULTIPLE URBAN CENTERS.—The Secretary, acting through the Service, may enter into a contract with,

or make grants to, an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to urban Indians in more than one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

''(a) AUTHORITY.—

''(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

''(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary

has entered into a contract with, or made a grant to, under this section.

''(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the urban Indian organization successfully undertake to—

''(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

''(B) with respect to urban Indians in the urban center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

''(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

''(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

''(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

''(1) conduct, through the Service, an annual onsite evaluation of the organization; or

''(2) accept, in lieu of an onsite evaluation, evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the medicare program under Title XVIII of the Social Security Act.

''(c) NONCOMPLIANCE.—

''(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

''(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

''(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has com-

pleted performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

''SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

''(a) APPLICATION OF FEDERAL LAW.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

''(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

''(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

''(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

''(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

''(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

''(a) REPORT.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

''(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

''(2) information on activities conducted by the organization pursuant to the contract or grant;

''(3) an accounting of the amounts and purposes for which Federal funds were expended; and

''(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary, after consultations consistent with section 514, with urban Indian organizations.

''(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

''SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

''The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

''SEC. 509. FACILITIES.

''(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

''(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

''(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

''(2) The total amount of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriations Acts.

''(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

''(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the revenue of the organization as security for a loan or loan guarantee under this subsection.

''(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

''(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

''(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

''(A) such amounts as may be appropriated to the URLF;

''(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

''(C) interest earned on amounts in the URLF under paragraph (3).

''(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

''(3) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet

current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

''SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

''There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to urban Indian organizations.

''SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

''(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom

the Secretary has entered into a contract under this title or under section 201.

''(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the—

''(1) size of the urban Indian population;

''(2) capability of the organization to adequately perform the activities required under the grant;

''(3) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

''(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

''(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance

abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) TULSA AND OKLAHOMA CITY CLINICS.—Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"(b) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a).

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2004, with urban Indian or-

ganizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with

urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

''(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

''SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

''For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting

from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian organization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

"(b) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

"(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

"(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within

the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

''(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian tribe or tribal organization, the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization if the Secretary receives the request from the Indian tribe

or tribal organization before the date on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

''(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

''SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

''(a) AUTHORITY.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention, treatment, and control of the complications resulting from, diabetes among urban Indians.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed upon between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

''(1) the size and location of the urban Indian population to be served;

''(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

''(3) performance standards for the urban Indian organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

''(4) the capability of the urban Indian organization to adequately perform the activities required under the grant; and

''(5) the willingness of the urban Indian organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the area office of the Service in which the organization is located.

''(d) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

''SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

''SEC. 520. REGULATIONS.

''(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

''(b) PROMULGATION.—

''(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

''(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270

days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

''(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

''(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursuant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

''(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

''SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

''(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

''(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

''(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

''(4) all scholarship and loan functions carried out under title I.

''(d) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

''(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within

the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, shall establish an automated management information system for the Service.

''(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

''(A) a financial management system;

''(B) a patient care information system;

''(C) a privacy component that protects the privacy of patient information;

''(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

''(E) an interface mechanism for patient billing and accounts receivable system; and

''(F) a training component.

''(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

''(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

''(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—It is the purpose of this section to—

''(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs;

''(2) provide information, direction and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement and judicial services;

''(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

''(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

''(5) ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access; and

''(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) BEHAVIORAL HEALTH PLANNING.—

''(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for In-

dian Behavioral Health Services. The plans shall, to the extent feasible, include—

''(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, dysfunctional and self-destructive behavior, including suicide, child abuse and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; and

''(ii) an estimate of the financial and human cost attributable to such illness or behavior;

''(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

''(C) an estimate of the additional funding needed by the Service, Indian tribes, tribal organizations and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary shall establish a national clearinghouse of

plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such plans and outcomes by any Indian tribe, tribal organization, urban Indian organization or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be utilized and adopted locally.

''(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

''(1) a comprehensive continuum of behavioral health care that provides for—

''(A) community based prevention, intervention, outpatient and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient or day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

''(G) emergency shelter;

''(H) intensive case management;

''(I) traditional health care practices; and

''(J) diagnostic services, including the utilization of neurological assessment technology; and

''(2) behavioral health services for particular populations, including—

''(A) for persons from birth through age 17, child behavioral health services, that include—

''(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

''(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

''(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, do-

mestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

''(v) female specific treatment services for—

''(I) women at risk of giving birth to a child with a fetal alcohol disorder;

''(II) substance abuse requiring gender specific services;

''(III) sexual assault and domestic violence; and

''(IV) healthy choices and life style (parenting, partners, obesity, suicide and other related behavioral risk); and

''(vi) male specific treatment services for—

''(I) substance abuse requiring gender specific services;

''(II) sexual assault and domestic violence; and

''(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

''(C) family behavioral health services, including—

''(i) early intervention, treatment and aftercare for affected families;

''(ii) treatment for sexual assault and domestic violence; and

''(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

''(D) for persons age 56 years and older, elder behavioral health services including—

''(i) early intervention, treatment and aftercare services that include—

''(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

''(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

''(III) healthy choices and life style services (managing conditions related to aging);

''(ii) elder women specific services that include—

''(I) treatment for substance abuse requiring gender specific services and

''(II) treatment for sexual assault, domestic violence and neglect;

''(iii) elder men specific services that include—

''(I) treatment for substance abuse requiring gender specific services; and

''(II) treatment for sexual assault, domestic violence and neglect; and

''(iv) services for dementia regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and

family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

''(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organiza-

tions, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

''(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

''SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

''(1) the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

''(2) the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

''(3) the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

''(4)(A) the right of Indians, as citizens of the United States and of the States in which they reside, to have access to mental health services to which all citizens have access;

''(B) the right of Indians to participate in, and receive the benefit of, such services; and

''(C) the actions necessary to protect the exercise of such right;

''(5) the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

''(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

''(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

''(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to community

behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412); and

''(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

''(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alco-

hol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

''(1) Indian tribes and tribal organizations;

''(2) Indian individuals;

''(3) urban Indian organizations and other Indian organizations;

''(4) behavioral health service providers.

''(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Federal Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including systems

of care and traditional health care practices, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

''(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children;

''(F) diagnostic services utilizing, when appropriate, neuropsychiatric assessments which include the use of the most advances technology available; and

''(G) a telepsychiatry program that uses experts in the field of pediatric psychiatry, and that incorporates assessment, diagnosis and

treatment for children, including those children with concurrent neurological disorders.

''(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

''(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional

Indian health care and treatment practices of the Indian tribes to be served.

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

"(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

"(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

''(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

''(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 707. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

''(B) AREA OFFICE IN CALIFORNIA.—For purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

''(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

''(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) that is agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

''(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska;

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

''(A) pre-treatment assistance;

''(B) inpatient, outpatient, and after-care services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness, and dysfunctional and self-destructive

behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided; and

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) to provide intensive home- and community-based services, including collaborative systems of care.

''(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of ap-

plications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youth; and

''(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and implement within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate.

Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youth residing in Indian communities, on Indian reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youth.

''SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION AND STAFFING ASSESSMENT.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems.

''(b) TREATMENT OF CALIFORNIA.—For purposes of this section, California shall be considered to be 2 areas

of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

''(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.

''SEC. 709. TRAINING AND COMMUNITY EDUCATION.

''(a) COMMUNITY EDUCATION.—

''(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

''(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

''(3) TRAINING.—Community-based training (oriented toward local capacity development) under a program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

''(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol

and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

''SEC. 710. BEHAVIORAL HEALTH PROGRAM.

''(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

''(1) Whether the project will address significant unmet behavioral health needs among Indians.

''(2) Whether the project will serve a significant number of Indians.

''(3) Whether the project has the potential to deliver services in an efficient and effective manner.

''(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

''(5) Whether the project will deliver services in a manner consistent with traditional health care.

''(6) Whether the project is coordinated with, and avoids duplication of, existing services.

''(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

''(a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

''(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

''(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

''(B) identify and provide behavioral health treatment to high-risk women;

''(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

''(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

''(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

''(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

''(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

''(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

''(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

''(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

''(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

''(c) TASK FORCE.—

''(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

''(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

''(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

''(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

''(1) victims of child sexual abuse; and

''(2) perpetrators of child sexual abuse.

''(b) USE OF FUNDS.—Funds provided under this section shall be used to—

''(1) develop and provide community education and prevention programs related to child sexual abuse;

''(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

''(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

''(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

''(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated, and to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

''SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

''(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian tribes, tribal organizations and urban Indian organizations or, enter into

contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the inter-relationship and inter-dependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(2) the development of models of prevention techniques.

''(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

''SEC. 714. DEFINITIONS.

''In this title:

''(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

''(2) ALCOHOL RELATED NEURODEVELOPMENTAL DISORDERS.—The term 'alcohol related

neurodevelopmental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

''(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(4) BEHAVIORAL HEALTH AFTERCARE.—

''(A) IN GENERAL.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse

or mental health outpatient or outpatient treatment, to help prevent or treat relapse, including the development of an aftercare plan.

''(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

''(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.

''(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

''(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

''(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following: microphthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(C) Prenatal or postnatal growth delay.

''(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

''(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.

''(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE VIII—MISCELLANEOUS

''SEC. 801. REPORTS.

''The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

''(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

''(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

''(3) a report on the use of health services by Indians—

''(A) on a national and area or other relevant geographical basis;

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

''(4) a report of contractors concerning health care educational loan repayments under section 110;

''(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

''(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

''(7) a report on infectious diseases as required under section 212;

''(8) a report on environmental and nuclear health hazards as required under section 214;

''(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

''(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

''(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

''(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

''(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

''(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

''(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

''(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

''(17) a report on the evaluation of programs as required under section 513; and

''(18) a report on alcohol and substance abuse as required under section 701(f).

''SEC. 802. REGULATIONS.

''(a) INITIATION OF RULEMAKING PROCEDURES.—

''(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian tribes.

''(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

''SEC. 804. AVAILABILITY OF FUNDS.

''Amounts appropriated under this Act shall remain available until expended.

''SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

''Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(A) Any member of a federally recognized Indian tribe.

"(B) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(i) is a member of the Indian community served by a local program of the Service; and

"(ii) is regarded as an Indian by the community in which such descendant lives.

"(C) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(D) Any Indian in California who is listed on the plans for distribution of the assets of

California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

''SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) INELIGIBLE PERSONS.—

''(1) IN GENERAL.—Any individual who—

''(A) has not attained 19 years of age;

''(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

''(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has

been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

''(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(b) PROGRAMS AND SERVICES.—

''(1) PROGRAMS.—

''(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other

subsection of this section or under any other provision of law if—

''(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

''(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

''(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

''(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

''(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

''(2) LIABILITY FOR PAYMENT.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880 of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

''(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

''(3) SERVICE AREAS.—

''(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

''(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

''(c) PURPOSE FOR PROVIDING SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

''(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

''(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

''(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

''SEC. 808. REALLOCATION OF BASE RESOURCES.

''(a) REQUIREMENT OF REPORT.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the Secretary has submitted to the

President, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

''SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

''SEC. 810. PROVISION OF SERVICES IN MONTANA.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

''(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service and, as such, may act as an ordering agent of the Service

and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

''(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

''(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

''(1) Ten members of Congress, of which—

''(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

''(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

''(C) two members shall be from the Senate and shall be appointed by the majority leader; and

''(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

''(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

''(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian tribes.

''(c) TERMS.—

''(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

''(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

''(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

''(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

''(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

''(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian tribes;

''(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

''(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

''(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provided, and the

cost, including mechanisms for funding of the health services to be provided;

''(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

''(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

''(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

''(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

''(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

''(e) ADMINISTRATIVE PROVISIONS.—

''(1) COMPENSATION AND EXPENSES.—

''(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States

Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(2) MEETINGS AND QUORUM.—

''(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

''(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

''(3) DIRECTOR AND STAFF.—

''(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(E) FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

''(f) POWERS.—

''(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, except that at least 6 regional hearings shall be held in different areas of the United States in which large numbers of Indians are present. Such hearings shall be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this paragraph, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established under this section may be counted towards the number of regional hearings required by this paragraph.

''(2) STUDIES BY GAO.—Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

''(3) COST ESTIMATES.—

''(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

''(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

''(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

''(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the

Commission as the Commission determines to be necessary to carry out its duties.

''(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

''(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

''(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

''SEC. 815. APPROPRIATIONS; AVAILABILITY.

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

''SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.''.

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

(3) by adding at the end the following:

''(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.''.

SEC. 202. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

''QUALIFIED INDIAN HEALTH PROGRAM

''SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

''(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

''(A) the Indian Health Service;

''(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; or

''(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

''(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

''(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under

this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

''(c) DETERMINATION OF PAYMENTS.—

''(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

''(2) DEFINITION OF FULL COST RECOVERY.—

''(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

''(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into account the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

''(ii) indirect costs which, in the case of a qualified Indian health program—

''(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

''(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

''(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

''(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

''(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

''(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

''(B) NO SINGLE REPORT REQUIREMENT.—Not all qualified Indian health programs provided or administered by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

''(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report

shall be made on a fee-for-service, encounter, or per diem basis.

''(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

''(A) a significant decrease in discharges;

''(B) costs for graduate medical education programs;

''(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

''(D) payment for outlier cases.

''(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

''(A) on the full cost recovery basis provided in paragraphs (1) through (5);

''(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

''(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

''(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian tribe or tribal organization; or

''(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

''(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

''(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal

organization, or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

''(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

''(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

''(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health set-

ting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

''(C) preventive primary health services as described under section 330 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

''(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screening, diagnostic, and treatment services as described in section 1905(r);

''(E) influenza and pneumococcal immunizations;

''(F) other immunizations for prevention of communicable diseases when targeted; and

''(G) the cost of transportation for providers or patients necessary to facilitate access for patients.''.

Subtitle B—Medicaid

SEC. 211. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (64), by striking ''and'' at the end:

(2) in paragraph (65), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (65), the following:

''(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

''(A) the term 'meaningful consultation' is defined through the negotiated rulemaking

process provided for under section 802 of the Indian Health Care Improvement Act; and

''(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.''.

SEC. 212. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.''.

SEC. 213. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

''INDIAN HEALTH SERVICE PROGRAMS

''SEC. 1911. (a) IN GENERAL.—The Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan by such entities if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement under this title and for services provided by a qualified Indian health program under section 1880A.

''(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be

deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

''(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations, or urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.''.

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking ''For purposes'' and inserting the following:

''(1) IN GENERAL.—Subject to paragraph (2), for purposes''; and

(2) by adding at the end the following:

''(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).''.

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting ''an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act),'' after ''Service,''.

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions

to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

SEC. 303. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect on October 1, 2003.

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108TH CONGRESS
1ST SESSION

H. R. 2440

To improve the implementation of the Federal responsibility for the care and education of Indian people by improving the services and facilities of Federal health programs for Indians and encouraging maximum participation of Indians in such programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 11, 2003

Mr. YOUNG of Alaska (for himself, Mr. HAYWORTH, Mr. RENZI, Mr. COLE, Mr. HUNTER, Mr. MCKEON, Mr. PALLONE, Mr. RAHALL, Mr. GEORGE MILLER of California, Mr. KILDEE, Mr. DINGELL, Mr. WAXMAN, Mr. RANGEL, Mr. CONYERS, Mr. OBERSTAR, Mr. GRIJALVA, Ms. MILLENDER-MCDONALD, Mr. FROST, Mr. KENNEDY of Rhode Island, Mr. FRANK of Massachusetts, Mr. FILNER, Mr. HONDA, Mr. CARSON of Oklahoma, Mr. ALLEN, Mr. ABERCROMBIE, Ms. LEE, Mrs. NAPOLITANO, Mr. FALEOMAVAEGA, Ms. MCCOLLUM, Mr. TOWNS, Mr. UDALL of New Mexico, Mr. UDALL of Colorado, Mr. KIND, Mr. LANTOS, Mr. INSLEE, Mr. STUPAK, Mr. BACA, Ms. KILPATRICK, Mrs. CHRISTENSEN, Mr. BLUMENAUER, and Ms. NORTON) introduced the following bill; which was referred to the Committee on Resources, and in addition to the Committees on Energy and Commerce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve the implementation of the Federal responsibility for the care and education of Indian people by improving the services and facilities of Federal health programs for Indians and encouraging maximum participation of Indians in such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Indian Health Care Improvement Act Amendments of 2003''.

SEC. 2. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

''SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

''(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

''(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

''SEC. 2. FINDINGS.

''Congress finds the following:

''(1) Federal delivery of health services and funding of Indian and Urban Indian Health Programs to maintain and improve the health of Indians are consonant with and required by the Federal Government's historical and unique legal relationship with Indians, as reflected in the Constitution, treaties, Federal statutes and the course of dealings of the United States with Indian Tribes and the United States' resulting government-to-government relationship with Indian Tribes and trust responsibilities and obligations to Indians.

''(2) From the time of European occupation and colonization through the 20th century, policies and practices of the United States caused and/or contributed to the severe health conditions of Indians.

''(3) Through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care, Indian Tribes have secured a de facto contract which entitles Indians to health care in perpetuity, based

on the moral, legal, and historic obligation of the United States.

''(4) The population growth of Indians that began in the later part of the 20th century increases the need for Federal health care services.

''(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians regardless of where they live to be raised to the highest possible level that is no less than that of the general population and to provide for the maximum participation of Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the planning, delivery and management of those health services.

''(6) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

''(7) Despite such services, the unmet health needs of Indians remain alarmingly severe and the health status of Indians is far below the health status of the general population of the United States.

''(8) The disparity to be addressed is formidable. For example, Indians suffer a death rate for diabetes mellitus that is 318 percent higher than the

all races rate for the United States, a pneumonia and influenza death rate 52 percent greater, a tuberculosis death rate that is 650 percent greater, and a death rate from alcoholism that is 670 percent higher than that of the all races United States rate.

''SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

''Congress hereby declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

''(1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

''(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010 or successor objectives;

''(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

''(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each

Service Area is raised to at least the level of that of the general population;

''(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

''(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

''SEC. 4. DEFINITIONS.

''For purposes of this Act:

''(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

''(2) The term 'Area Office' means an administrative entity including a program office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

''(3) The term 'California Indians' shall mean those Indians who are eligible for health services of the Service pursuant to section 806.

''(4) The term 'community college' means—

''(A) a tribal college or university, or

''(B) a junior or community college.

''(5) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

''(6) The term 'Department' means, unless otherwise designated, the Department of Health and Human Services.

''(7) The term 'Director' means the Director of the Indian Health Service.

''(8) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including, but not limited to—

''(A) controlling—

''(i) development of diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

''(i) fluoridation of water; and

''(ii) immunizations.

''(9) The term 'fund' or 'funding' means the transfer of moneys from the Department to any eligible entity or individual under this Act by any legal means, including Funding Agreements, contracts, memoranda of understanding, contracts pursuant to section 23 of the Act of April 20, 1908 (25 U.S.C. 47; popularly known as the 'Buy Indian Act'), or otherwise.

''(10) The term 'Funding Agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, services, functions, and activities to Indian Tribes and Tribal Organizations from the Secretary under the Indian Self-Determination and Education Assistance Act.

''(11) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, op-

tometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, and any other health profession.

''(12) The term 'health promotion' means—

''(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

''(B) encouraging adequate and appropriate diet, exercise, and sleep;

''(C) promoting education and work in conformity with physical and mental capacity;

''(D) making available suitable housing, safe water, and sanitary facilities;

''(E) improving the physical, economic, cultural, psychological, and social environment;

''(F) promoting adequate opportunity for spiritual, religious, and Traditional Health Care Practices; and

''(G) providing adequate and appropriate programs, including, but not limited to—

"(i) abuse prevention (mental and physical);

"(ii) community health;

"(iii) community safety;

"(iv) consumer health education;

"(v) diet and nutrition;

"(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

"(vii) environmental health;

"(viii) exercise and physical fitness;

"(ix) avoidance of fetal alcohol disorders;

"(x) first aid and CPR education;

"(xi) human growth and development;

"(xii) injury prevention and personal safety;

"(xiii) mental health;

"(xiv) personal health and wellness practices;

"(xv) personal capacity building;

"(xvi) prenatal, pregnancy, and infant care;

"(xvii) psychological well-being;

''(xviii) reproductive health and family planning;

''(xix) safe and adequate water;

''(xx) safe housing;

''(xxi) safe work environments;

''(xxii) stress control;

''(xxiii) substance abuse;

''(xxiv) sanitary facilities;

''(xxv) tobacco use cessation and reduction;

''(xxvi) violence prevention; and

''(xxvii) such other activities identified by the Service, a Tribal Health Program, or an Urban Indian Organization, to promote achievement of any of the objectives described in section 3(2).

''(13) The term 'Indian' shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

''(14) The term 'Indian Health Program' means the following—

''(A) any health program administered directly by the Service;

''(B) any Tribal Health Program; or

''(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of April 30, 1908 (25 U.S.C. 47), popularly known as the 'Buy Indian Act'.

''(15) The term 'Indian Tribe' shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

''(16) The term 'junior or community college' has the meaning given to such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(17) The term 'reservation' means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (25 U.S.C. 1601 et seq.).

''(18) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

''(19) The term 'Service' means the Indian Health Service.

''(20) The term 'Service Area' means the geographical area served by each Area Office.

''(21) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

''(22) The term 'Traditional Health Care Practices' means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.

''(23) The term 'tribal college or university' shall have the meaning given that term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

''(24) The term 'Tribal Health Program' means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a Funding Agreement

with the Service under the Indian Self-Determination and Education Assistance Act.

''(25) The term 'Tribal Organization' shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

''(26) The term 'Urban Center' means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

''(27) The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

''(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

''(B) The individual is an Eskimo, Aleut, or other Alaskan Native.

''(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

''(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

''(28) The term 'Urban Indian Organization' means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) provides for the participation of all interested Indian groups and individuals; and (D) is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

"SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and Urban Indian Organizations involved in the provision of health services to Indians.

"SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available to public or nonprofit private health entities or Tribal Health Programs to assist such entities in meeting the costs of—

''(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

''(A) to enroll in courses of study in such health professions; or

''(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

''(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

''(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) FUNDING.—

''(1) APPLICATION.—Funds under this section shall require that an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give a preference to applications submitted by Tribal Health Programs or Urban Indian Organizations.

''(2) AMOUNT OF FUNDS; PAYMENT.—The amount of funds provided to entities under this section shall be determined by the Secretary. Payments pursuant to this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, funding commitments shall be for 3 years, as provided in regulations published pursuant to this Act.

''(c) DEFINITION OF INDIAN.—For purposes of this section and sections 103 and 104, the term 'Indian' shall, in addition to the meaning given that term in section 4, also mean any individual who is an Urban Indian.

"SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

''(a) SCHOLARSHIPS AUTHORIZED.—The Secretary, acting through the Service, shall provide scholarships to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

''(2) have demonstrated the potential to successfully complete courses of study in the health professions.

''(b) PURPOSES.—Scholarships provided pursuant to this section shall be for the following purposes:

''(1) Compensatory preprofessional education of any recipient, such scholarship not to exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued under this Act).

''(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years. An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.

''(c) OTHER CONDITIONS.—Scholarships under this section—

''(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

''(2) shall not be denied solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

''(3) shall not be denied solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

''SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

''(a) IN GENERAL.—

''(1) AUTHORITY.—The Secretary, acting through the Service, shall make scholarships to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Services Act (42 U.S.C. 2541), except as provided in subsection (b) of this section.

''(2) ALLOCATION BY FORMULA.—Except as provided in paragraph (3), the funding authorized

by this section shall be allocated by Service Area by a formula developed in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. Such formula shall consider the human resource development needs in each Service Area.

''(3) CONTINUITY OF PRIOR SCHOLARSHIPS.—Paragraph (2) shall not apply with respect to individual recipients of scholarships provided under this section (as in effect 1 day prior to the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003) until such time as the individual completes the course of study that is supported through such scholarship.

''(4) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Director and shall not be delegated in a Funding Agreement.

''(b) ACTIVE DUTY SERVICE OBLIGATION.—

''(1) OBLIGATION MET.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year-for-

year obligation, by service in one or more of the following:

"(A) In an Indian Health Program.

"(B) In a program assisted under title V.

"(C) In the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(2) OBLIGATION DEFERRED.—At the request of any individual who has entered into a contract referred to in paragraph (1) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

''(A) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service under this subsection.

''(B) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

''(C) The active duty service obligation will be served in the health profession of that individual in a manner consistent with paragraph (1).

''(D) A recipient of a scholarship under this section may, at the election of the recipient, meet the active duty service obligation described in paragraph (1) by service in a program specified under that paragraph that—

''(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

''(ii) serves the Indian Tribe in which the recipient is enrolled.

''(3) PRIORITY WHEN MAKING ASSIGNMENTS.—Subject to paragraph (2), the Secretary, in making

assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in paragraph (1), shall give priority to assigning individuals to service in those programs specified in paragraph (1) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(c) PART-TIME STUDENTS.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

''(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the Area Office;

''(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

''(A) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the Area Office); or

''(B) 2 years; and

''(3) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254*l*(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary)

based on the number of hours such student is enrolled.

''(d) BREACH OF CONTRACT.—

''(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003 if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in

part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1) an individual breaches a written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) WAIVERS AND SUSPENSIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, determines that—

''(A) it is not possible for the recipient to meet that obligation or make that payment;

''(B) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(C) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(5) EXTREME HARDSHIP.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

''(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

"SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall provide funding grants to at least 3 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

''(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of funds provided under this section.

''(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

''(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

''(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

''(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

''(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

''(7) to the maximum extent feasible, employs qualified Indians in the program.

''(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

''(1) in an Indian Health Program;

''(2) in a program assisted under title V; or

''(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

''SEC. 106. FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.

''(a) IN GENERAL.—

''(1) FUNDING AUTHORIZED.—The Secretary, acting through the Service, shall make funds available to Tribal Health Programs for the purpose of assisting such Tribal Health Programs in educating Indians to serve as health professionals in Indian communities.

''(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

''(3) APPLICATION.—An application for funds under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—A Tribal Health Program receiving funds under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

''(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

''(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

''(B) 20 percent of such costs may be paid from any other source of funds.

''(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of

study (approved by the Secretary) in one of the health professions contemplated by this Act.

''(d) CONTRACT.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship. Such contract shall—

''(1) obligate such recipient to provide service in an Indian Health Program or Urban Indian Organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

''(A) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

''(B) such greater period of time as the recipient and the Tribal Health Program may agree;

''(2) provide that the amount of the scholarship—

''(A) may only be expended for—

''(i) tuition expenses, other reasonable educational expenses, and reasonable living

expenses incurred in attendance at the educational institution; and

''(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled; and may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

''(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

''(3) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(4) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

''(e) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

''(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level as determined by the educational institution under regulations of the Secretary);

''(B) is dismissed from such educational institution for disciplinary reasons;

''(C) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

''(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in

part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

''(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

''(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

''(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in

providing health care pursuant to the requirements herein—

''(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

''(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

''(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal

Health Program has not complied with the requirements of this section.

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

''(a) EMPLOYMENT PREFERENCE.—Any individual who receives a scholarship pursuant to sections 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an Urban Indian Organization, or other agencies of the Department as available, during any nonacademic period of the year.

''(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted in determining fulfillment of the service obligation incurred as a condition of the scholarship.

''(c) TIMING; LENGTH OF EMPLOYMENT.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an Urban Indian Organization during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

''(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—Any employment pursuant to this section shall be made without regard to any competitive personnel

system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

''SEC. 108. CONTINUING EDUCATION ALLOWANCES.

''In order to encourage health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian Health Program or an Urban Indian Organization and to provide their services in the rural and remote areas where a significant portion of Indians reside, the Secretary, acting through the Service Area, may provide allowances to health professionals employed in an Indian Health Program or an Urban Indian Organization to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

''(1) provide for the training of Indians as community health representatives; and

''(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

''(b) DUTIES.—The Community Health Representative Program of the Service, shall—

''(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by the Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

''(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

''(4) maintain a system that provides close supervision of Community Health Representatives;

''(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

''(6) promote Traditional Health Care Practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Service Loan Repayment Pro-

gram (hereinafter referred to as the 'Loan Repayment Program') in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and Urban Indian Organizations.

''(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

''(1)(A) be enrolled—

''(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254*l*–1(b)(1)(c)(i))) and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

''(ii) in an approved graduate training program in a health profession; or

''(B) have—

''(i) a degree in a health profession; and

''(ii) a license to practice a health profession;

''(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

''(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

''(C) meet the professional standards for civil service employment in the Service; or

''(D) be employed in an Indian Health Program or Urban Indian Organization without a service obligation; and

''(3) submit to the Secretary an application for a contract described in subsection (e).

''(c) APPLICATION.—

''(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (*l*) in the case of the individual's breach of contract. The Secretary shall

provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make a decision on an informed basis.

''(2) CLEAR LANGUAGE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

''(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) PRIORITIES.—

''(1) LIST.—Consistent with subsection (k), the Secretary shall annually—

''(A) identify the positions in each Indian Health Program or Urban Indian Organization for which there is a need or a vacancy; and

''(B) rank those positions in order of priority.

''(2) APPROVALS.—Notwithstanding the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

''(A) give first priority to applications made by individual Indians; and

''(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

''(i) individuals recruited through the efforts of a Tribal Health Program or Urban Indian Organization; and

''(ii) other individuals based on the priority rankings under paragraph (1).

''(e) RECIPIENT CONTRACTS.—

''(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

"(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(A) an agreement under which—

"(i) subject to subparagraph (C), the Secretary agrees—

"(I) to pay loans on behalf of the individual in accordance with the provisions of this section; and

"(II) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a Tribal Health Program or Urban Indian Organization as provided in clause (ii)(III); and

"(ii) subject to subparagraph (C), the individual agrees—

"(I) to accept loan payments on behalf of the individual;

"(II) in the case of an individual described in subsection (b)(1)—

"(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A)

until the individual completes the course of study or training; and

"(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

"(III) to serve for a time period (hereinafter in this section referred to as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian Health Program or Urban Indian Organization to which the individual may be assigned by the Secretary;

"(B) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obli-

gated service agreed to by the individual under subparagraph (A)(ii)(III);

''(C) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

''(D) a statement of the damages to which the United States is entitled under subsection (*l*) for the individual's breach of the contract; and

''(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

''(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

''(2) the Secretary's disapproving an individual's participation in such Program.

''(g) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT.—For each year of obligated service that an individual contracts to serve under subsection (e), the Secretary may pay up to $35,000 or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act, whichever is more, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall

consider the extent to which each such determination—

''(A) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

''(B) provides an incentive to serve in Indian Health Programs and Urban Indian Organizations with the greatest shortages of health professionals; and

''(C) provides an incentive with respect to the health professional involved remaining in an Indian Health Program or Urban Indian Organization with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

''(3) TIMING.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(4) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

''(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

''(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other Service manpower programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

''(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or Urban Indian Organizations pursuant to contracts entered into under this section, shall—

''(1) ensure that the staffing needs of Tribal Health Programs and Urban Indian Organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

''(2) give priority to assigning individuals to Indian Health Programs and Urban Indian Organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(*l*) BREACH OF CONTRACT.—

''(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual—

''(A) is enrolled in the final year of a course of study and—

''(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is

enrolled (such level determined by the educational institution under regulations of the Secretary);

''(ii) voluntarily terminates such enrollment; or

''(iii) is dismissed from such educational institution before completion of such course of study; or

''(B) is enrolled in a graduate training program and fails to complete such training program.

''(2) OTHER BREACHES; FORMULA FOR AMOUNT OWED.—If, for any reason not specified in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (e)(2), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: A=3Z(t-s/t) in which—

''(A) 'A' is the amount the United States is entitled to recover;

''(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the indi-

vidual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury;

''(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

''(D) 's' is the number of months of such period served by such individual in accordance with this section.

''(3) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in medicare payments pursuant to section 1892 of the Social Security Act.

''(4) TIME PERIOD FOR REPAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

''(5) RECOVERY OF DELINQUENCY.—

''(A) IN GENERAL.—If damages described in paragraph (4) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

''(i) use collection agencies contracted with by the Administrator of General Services; or

''(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

''(B) REPORT.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

''(m) WAIVER OR SUSPENSION OF OBLIGATION.—

''(1) IN GENERAL.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible

or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

''(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

''(3) HARDSHIP WAIVER.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

''(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

''(n) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to Congress under section 801, a report concerning

the previous fiscal year which sets forth by Service Area the following:

''(1) A list of the health professional positions maintained by Indian Health Programs and Urban Indian Organizations for which recruitment or retention is difficult.

''(2) The number of Loan Repayment Program applications filed with respect to each type of health profession.

''(3) The number of contracts described in subsection (e) that are entered into with respect to each health profession.

''(4) The amount of loan payments made under this section, in total and by health profession.

''(5) The number of scholarships that are provided under section 104 and 106 with respect to each health profession.

''(6) The amount of scholarship grants provided under section 104 and 106, in total and by health profession.

''(7) The number of providers of health care that will be needed by Indian Health Programs and Urban Indian Organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.

''(8) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or Urban Indian Organizations for which recruitment or retention is difficult.

''SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

''(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the 'LRRF'). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110(*l*) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

''(b) USE OF FUNDS.—

''(1) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

''(A) to which a scholarship recipient under section 104 and 106 or a loan repayment pro-

gram participant under section 110 has been assigned to meet the obligated service requirements pursuant to such sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104, 106, or section 110.

''(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or recruit and employ, directly or by contract, health professionals to provide health care services.

''(c) INVESTMENT OF FUNDS.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary of Health and Human Services determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(d) SALE OF OBLIGATIONS.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

''SEC. 112. RECRUITMENT ACTIVITIES.

''(a) REIMBURSEMENT FOR TRAVEL.—The Secretary, acting through the Service, may reimburse health professionals seeking positions with Indian Health Programs or Urban Indian Organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

''(b) RECRUITMENT PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each Area Office to be responsible on a full-time basis for recruitment activities.

''SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall fund innovative demonstration projects for a period not to exceed 3 years to enable Tribal Health Programs and Urban Indian Organizations to recruit,

place, and retain health professionals to meet their staffing needs.

''(b) ELIGIBLE ENTITIES; APPLICATION.—Any Tribal Health Program or Urban Indian Organization may submit an application for funding of a project pursuant to this section.

''SEC. 114. ADVANCED TRAINING AND RESEARCH.

''(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of the enactment

of the Indian Health Care Improvement Act Amendments of 2003, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from Tribal Health Programs and Urban Indian Organizations shall be given an equal opportunity to participate in the program under subsection (a).

''SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

''(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

''(1) Public or private schools of nursing.

''(2) Tribal colleges or universities.

''(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

''(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for one or more of the following:

''(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

''(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

''(3) To provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians.

''(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

''(5) To provide any program that is designed to achieve the purpose described in subsection (a).

''(c) APPLICATIONS.—Each application for funding under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

''(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

''(1) Programs that provide a preference to Indians.

''(2) Programs that train nurse midwives or advanced practice nurses.

''(3) Programs that are interdisciplinary.

''(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

''(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

''(f) ACTIVE DUTY SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assist-

ance described in paragraph (1) or (2) of subsection (b) that is funded by a grant provided under subsection (a). Such obligation shall be met by service—

''(1) in the Service;

''(2) in a program of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination Act (including programs under agreements with the Bureau of Indian Affairs);

''(3) in a program assisted under title V of this Act; or

''(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health shortage area and addresses the health care needs of a substantial number of Indians.

''SEC. 116. TRIBAL CULTURAL ORIENTATION.

''(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.

''(b) PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

''(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;

''(2) be carried out through tribal colleges or universities;

''(3) include instruction in American Indian studies; and

''(4) describe the use and place of Traditional Health Care Practices of the Indian Tribes in the Service Area.

''SEC. 117. INMED PROGRAM.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Indian health careers recruitment program known as the 'Indians Into Medicine Program' (hereinafter in this section referred to as 'INMED') as a means of encouraging Indians to enter the health professions.

''(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N.

Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

''(c) REGULATIONS.—The Secretary, pursuant to this Act, shall develop regulations to govern grants pursuant to this section.

''(d) REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program which—

''(1) provides outreach and recruitment for health professions to Indian communities including elementary and secondary schools and community colleges located on reservations which will be served by the program;

''(2) incorporates a program advisory board comprised of representatives from the Indian Tribes and Indian communities which will be served by the program;

''(3) provides summer preparatory programs for Indian students who need enrichment in the subjects

of math and science in order to pursue training in the health professions;

''(4) provides tutoring, counseling, and support to students who are enrolled in a health career program of study at the respective college or university; and

''(5) to the maximum extent feasible, employs qualified Indians in the program.

''SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

''(a) GRANTS TO ESTABLISH PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such community colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program.

''(2) AMOUNT OF GRANTS.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

''(b) GRANTS FOR MAINTENANCE AND RECRUITING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

''(2) REQUIREMENTS.—Grants may only be made under this section to a community college which—

''(A) is accredited;

''(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

''(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

''(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

''(D) has a qualified staff which has the appropriate certifications;

''(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs; and

''(2) providing technical assistance and support to such colleges.

''(d) ADVANCED TRAINING.—

''(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses

of study which provide advanced training for any health professional who—

''(A) has already received a degree or diploma in such health profession; and

''(B) provides clinical services on or near a reservation or for an Indian Health Program.

''(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

''(e) FUNDING PRIORITY.—Where the requirements of subsection (b) are met, funding priority shall be provided to tribal colleges and universities in Service Areas where they exist.

''SEC. 119. RETENTION BONUS.

''(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, an Indian Health Program or Urban Indian Organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

''(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by Indian Health Programs and Urban Indian Organizations;

"(3) has—

"(A) completed 3 years of employment with an Indian Health Program or Urban Indian Organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with an Indian Health Program or Urban Indian Organization for continued employment for a period of not less than 1 year.

"(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

"(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon

term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(*l*)(2)(B).

''(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

''(1) a position for which recruitment or retention is difficult; and

''(2) necessary for providing health care services to Indians.

''SEC. 120. NURSING RESIDENCY PROGRAM.

''(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or Urban Indian Organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study in an Indian Health Program or Urban Indian Organiza-

tion leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor's degree (in the case of a registered nurse), or advanced degrees in nursing and public health.

''(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (*l*) of section 110 in the manner provided for in such subsection.

''SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

''(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

''(1) provides for the training of Alaska Natives as health aides or community health practitioners;

''(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

''(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

''(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

''(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

''(2) in order to provide such training, develop a curriculum that—

''(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

''(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

''(C) promotes the achievement of the health status objectives specified in section 3(2);

''(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

''(c) NATIONAL COMMUNITY HEALTH AIDE PROGRAM.—The Secretary, acting through the Service, shall develop and operate a national Community Health Aide Program consistent with the requirements of this section without reducing funds for the Community Health Aide Program for Alaska.

''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

''The Secretary, acting through the Service, shall, by funding agreement or otherwise, provide training for Indians in the administration and planning of Tribal Health Programs.

''SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

''(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

''(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

''(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

''(2) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

''(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

''(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

''SEC. 124. TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.

''Scholarships provided to individuals pursuant to this title shall be deemed 'qualified Scholarships' for purposes of section 11 of the Internal Revenue Code of 1986.

''SEC. 125. NATIONAL HEALTH SERVICE CORPS.

''(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

''(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or

''(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations, has ensured that the Indians receiving services from such member will experience no reduction in services.

''(b) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

''SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

''(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

''(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1-year period upon the approval of the Secretary.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

''(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to en-

able grant recipients to comply with the provisions of this section.

''(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

''(g) DEFINITION.—For the purposes of this section the term 'educational curriculum' means 1 or more of the following—

''(1) classroom education;

''(2) clinical work experience; and

''(3) continuing education workshops.

"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

''(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

''(b) POSITIONS.—The positions referred to in subsection (a) are—

''(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

''(A) elementary and secondary education;

''(B) social services and family and child welfare;

''(C) law enforcement and judicial services; and

''(D) alcohol and substance abuse;

''(2) staff positions within the Service; and

''(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations, (without regard to the funding source) and Urban Indian Organizations.

''(c) TRAINING CRITERIA.—

''(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3),

the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or Urban Indian Organization for training of appropriate individuals. In the case of positions funded under a funding agreement, the appropriate Secretary shall ensure that funds to cover the costs of such training costs are included in the funding agreement.

''(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding Traditional Health Care Practices is provided.

''(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe or Tribal Organization, or assist the Indian Tribe or Tribal Organization to develop and implement a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe or Tribal Organization, provide technical assistance to the Indian Tribe or Tribal Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

''(e) PLAN.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within 5 years after the date of the enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13, popularly known as the Snyder Act).

''SEC. 128. DESIGNATION OF SHORTAGE AREAS.

''A Service Area served by an Indian Health Program or Urban Indian Organization shall be designated under the Public Health Services Act (42 U.S.C. 250 et seq.) as a shortage area immediately upon request of an Indian Health Program without further evaluation by the Secretary.

''SEC. 129. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, which are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in health status and health resources of all Indian Tribes;

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies:

''(A) Clinical care, including, but not limited to, inpatient care, outpatient care (including audiology, clinical eye, and vision care), pri-

mary care, secondary and tertiary care, and long-term care.

''(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

''(C) Dental care.

''(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

''(E) Emergency medical services.

''(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

''(G) Accident prevention programs.

''(H) Home health care.

''(I) Community health representatives.

''(J) Maintenance and repair.

''(K) Traditional Health Care Practices.

''(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to

the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13, popularly known as the Snyder Act), or any other provision of law.

''(c) ALLOCATION; USE.—

''(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Indian Tribe, Tribal Organization, or Service Unit under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

''(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes and Tribal Organizations.

''(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

''(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

''(A) the health status objectives set forth in section 3(2) are not being achieved; and

''(B) the Indian Tribe or Tribal Organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

''(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

''(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian Tribe or Tribal Organization to petition the Secretary for a review of any determination of the extent of the health status and re-

source deficiency of such Indian Tribe or Tribal Organization.

''(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

''(f) REPORT.—By no later than the date that is 3 years after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out—

''(1) the methodology then in use by the Service for determining Tribal health status and resource deficiencies, as well as the most recent application of that methodology;

''(2) the extent of the health status and resource deficiency of each Indian Tribe served by the Service or a Tribal Health Program;

''(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian Tribes served by the Service or a Tribal Health Program; and

''(4) an estimate of—

''(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service Unit, Indian Tribe, or Tribal Organization;

''(B) the number of Indians eligible for health services in each Service Unit or Indian Tribe or Tribal Organization; and

''(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts

to achieve equity among Indian Tribes and Tribal Organizations.

''(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—There is hereby established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'CHEF') consisting of—

''(1) the amounts deposited under subsection (f); and

''(2) the amounts appropriated to CHEF under this section.

''(b) ADMINISTRATION.—CHEF shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

''(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination Act, nor shall CHEF funds be allocated, appor-

tioned, or delegated on an Area Office, Service Unit, or other similar basis.

''(d) REGULATIONS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section to—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from CHEF;

''(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) the 2000 level of $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year; and

"(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

"(A) Service Units; or

"(B) whenever otherwise authorized by the Service, non-Service facilities or providers;

"(4) establish a procedure for payment from CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

"(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13, popularly known as the Snyder Act), or any other law.

"(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason

of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF.

"SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

"(a) FINDINGS.—Congress finds that health promotion and disease prevention activities—

"(1) improve the health and well-being of Indians; and

"(2) reduce the expenses for health care of Indians.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and Tribal Health Programs, shall provide health promotion and disease prevention services to Indians to achieve the health status objectives set forth in section 3(2).

"(c) EVALUATION.—The Secretary, after obtaining input from the affected Tribal Health Programs, shall submit to the President for inclusion in each report which is required to be submitted to Congress under section 801 an evaluation of—

"(1) the health promotion and disease prevention needs of Indians;

"(2) the health promotion and disease prevention activities which would best meet such needs;

''(3) the internal capacity of the Service and Tribal Health Programs to meet such needs; and

''(4) the resources which would be required to enable the Service and Tribal Health Programs to undertake the health promotion and disease prevention activities necessary to meet such needs.

''SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

''(1) by an Indian Tribe, Tribal Organization, and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

''(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education) each Service Unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian Tribes within that Service Unit.

''(b) DIABETES SCREENING.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the

Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by a Tribal Health Program.

''(c) FUNDING FOR DIABETES.—The Secretary shall continue to fund each model diabetes project in existence on the date of the enactment of the Indian Health Amendments Care Improvement Act of 2003, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2003 and for projects which are added and funded thereafter.

''(d) FUNDING FOR DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian Tribes, and Tribal Organizations to establish dialysis programs, including funding to purchase dialysis equipment and provide necessary staffing.

''(e) OTHER DUTIES OF THE SECRETARY.—The Secretary shall, to the extent funding is available—

''(1) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

''(2) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

''(3) ensure that data collected in each Area Office regarding diabetes and related complications among Indians is disseminated to all other Area Offices.

''SEC. 205. SHARED SERVICES FOR LONG-TERM CARE.

''(a) FUNDING AGREEMENTS FOR LONG-TERM CARE.—Notwithstanding any other provisions of law, the Secretary, acting through the Service, is authorized to enter into Funding Agreements or other arrangements with Indian Tribes or Tribal Organizations for the delivery of long-term care and similar services to Indians. Such funding agreements or other arrangements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or other similar facility owned and operated (directly or through a Funding Agreement) by such Indian Tribe or Tribal Organization.

''(b) CONTENTS OF FUNDING AGREEMENTS.—A Funding Agreement or other arrangement entered into pursuant to subsection (a)—

''(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

''(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

''(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

''(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

''SEC. 206. HEALTH SERVICES RESEARCH.

''The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs and shall coordinate the activities of other agencies within the Department to address these research needs. The funding shall be divided equitably among the Area Offices. Then each Area Office shall award the funds competitively within that Area. The Secretary shall consult with Indian Tribes and Tribal Organizations in developing the methodology used to allocate these funds among Area Offices for competitive awards. Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section. This funding may be used for both clinical and nonclinical research.

''SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

''The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

''(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, such as those of the National Cancer Institute for the National Institutes for Health, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

''(2) Other cancer screening meeting national standards, such as those of the National Cancer Institute.

''SEC. 208. PATIENT TRAVEL COSTS.

''The Secretary, acting through the Service and Tribal Health Programs, shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving health care services provided (either through direct or contract care or through Funding Agreements) under this Act—

''(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

''(2) transportation by private vehicle, specially equipped vehicle, and ambulance; and

''(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

''SEC. 209. EPIDEMIOLOGY CENTERS.

''(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established at the time of enactment of this Act, (including those for which funding is currently being provided in Funding Agreements), and without reducing the funding levels for such centers, not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, shall establish and fund an epidemiology center in each Service Area which does not yet have one to carry out the functions described in subsection (b). Any new centers so established may be operated by Tribal Health Programs, but such funding shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this subsection shall, with respect to such Service Area—

''(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes,

Tribal Organizations, and Urban Indian Organizations in the Service Area;

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

''(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

''(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

''(d) FUNDING FOR STUDIES.—The Secretary may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.

''SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—The Secretary, acting through the Service, shall provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and Urban Indian children.

''(b) USE OF FUNDS.—Funding provided under this section may be used for purposes which may include, but are not limited to, the following:

''(1) Developing and implementing health education curricula both for regular school programs and afterschool programs.

''(2) Training teachers in comprehensive school health education curricula.

''(3) Integrating school-based, community-based, and other public and private health promotion efforts.

''(4) Encouraging healthy, tobacco-free school environments.

''(5) Coordinating school-based health programs with existing services and programs available in the community.

''(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

''(7) Developing mental health wellness programs.

''(8) Developing chronic disease prevention programs.

''(9) Developing substance abuse prevention programs.

''(10) Developing injury prevention and safety education programs.

''(11) Developing activities for the prevention and control of communicable diseases.

''(12) Developing community and environmental health education programs that include traditional health care practitioners.

''(13) Violence prevention.

''(14) Such other health issues as are appropriate.

''(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications for funding provided pursuant to this section.

''(e) DEVELOPMENT OF PROGRAM FOR BIA FUNDED SCHOOLS.—

''(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, and affected Indian Tribes and Tribal Organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

''(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include the following—

''(A) school programs on nutrition education, personal health, oral health, and fitness;

''(B) mental health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

''(E) injury prevention and safety education programs; and

''(F) activities for the prevention and control of communicable diseases.

''(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

''(A) provide training to teachers in comprehensive school health education curricula;

''(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

''(C) encourage healthy, tobacco-free school environments.

''SEC. 211. INDIAN YOUTH PROGRAM.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and admin-

ister a program to provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths.

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funds made available under this section may be used to—

''(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

''(B) develop and provide community training and education.

''(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(c).

''(c) DUTIES OF THE SECRETARY.—The Secretary shall—

''(1) disseminate to Indian Tribes, Tribal Organizations, and Urban Indian Organizations information regarding models for the delivery of comprehensive health care services to Indian and Urban Indian adolescents;

''(2) encourage the implementation of such models; and

''(3) at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance in the implementation of such models.

''(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organization, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

''SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

''(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, and after consultation with Indian Tribes, Tribal Organizations, Urban Indian Organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian Tribes and Tribal Organizations for the following:

''(1) Projects for the prevention, control, and elimination of communicable and infectious diseases including, but not limited to, tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

''(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

''(3) Education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

''(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

''(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

''(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes and Tribal Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

''(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

''(1) may, at the request of an Indian Tribe or Tribal Organization, provide technical assistance; and

''(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

''SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.

''(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act, which shall include, but not be limited to—

''(1) hospice care and assisted living;

''(2) long-term health care;

''(3) home- and community-based services;

''(4) public health functions; and

''(5) Traditional Health Care Practices.

''(b) SERVICES TO OTHERWISE INELIGIBLE PERSONS.—At the discretion of the Service, Indian Tribes, or Tribal Organizations, services provided for hospice care, home health care, home- and community-based care, assisted living, and long-term care may be provided (subject to reimbursement of reasonable charges) to persons other-

wise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to an Indian Tribe or Tribal Organization.

''(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

''(1) The term 'home- and community-based services' means 1 or more of the following:

''(A) Homemaker/home health aide services.

''(B) Chore services.

''(C) Personal care services.

''(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

''(E) Respite care.

''(F) Training for family members.

''(G) Adult day care.

''(H) Such other home- and community-based services as the Secretary, an Indian Tribe, or Tribal Organization may approve.

''(2) The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other serv-

ices which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

''(3) The term 'public health functions' means the provision of public health-related programs, functions, and services including, but not limited to, assessment, assurance, and policy development which Indian Tribes and Tribal Organizations are authorized and encouraged, in those circumstances where it meets their needs, to do by forming collaborative relationships with all levels of local, State, and Federal Government.

''SEC. 214. INDIAN WOMEN'S HEALTH CARE.

''The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

''SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

''(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with con-

cerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

''(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

''(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

''(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including, but not limited to, uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that

could affect the health of Indians and their water supply and food chain;

''(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

''(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

''(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and, in consultation with Indian Tribes and Tribal Organizations, develop health care plans to address the health problems studied under subsection (a). The plans shall include—

''(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

''(2) preventive care and testing for Indians who may be exposed to such health hazards, includ-

ing the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

''(d) INTERGOVERNMENTAL TASK FORCE.—

''(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be

composed of the following individuals (or their designees):

''(A) The Secretary of Energy.

''(B) The Secretary of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(F) The Secretary of Health and Human Services.

''(G) The Director of the Indian Health Service.

''(2) DUTIES.—The Task Force shall—

''(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

''(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

''(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

''(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work-related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program

from the employer for providing medical care for such illness or condition.

"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2015, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

"(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 216A. NORTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of North Dakota shall be designated as a contract health service delivery area by the Service for the purpose of pro-

viding contract health care services to members of federally recognized Indian Tribes of North Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of North Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

''SEC. 216B. SOUTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending on September 30, 2015, the State of South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of South Dakota.

''(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of South Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.

"(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

"(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

"(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise

made available to the California contract health service delivery area for a fiscal year.

''(e) ADVISORY BOARD.—There is hereby established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least one half of whom of whom are not affiliated with the CRIHB.

''SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

''The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

"(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

"(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

"The Service shall provide funds for health care programs and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

"Health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the

Tribal Health Program performs the services described in its Funding Agreement.

''SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

''With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

''SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

''(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

''(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

''(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

''(a) NO PATIENT LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

''(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services.

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) PREREQUISITES FOR EXPENDITURE OF FUNDS.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall—

"(1) consult with any Indian Tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

"(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the medicare, medicaid, and SCHIP programs under title XVIII, XIX, and XXI of the Social Security Act by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURES.—

''(1) EVALUATION REQUIRED.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress at least 1 year prior to the date of the proposed closure an evaluation of the impact of the proposed closure which specifies, in addition to other considerations the following:

''(A) The accessibility of alternative health care resources for the population served by such facility.

''(B) The cost-effectiveness of such closure.

''(C) The quality of health care to be provided to the population served by such facility after such closure.

''(D) The availability of contract health care funds to maintain existing levels of service.

''(E) The views of the Indian Tribes served by such facility concerning such closure.

''(F) The level of use of such facility by all eligible Indians.

''(G) The distance between such facility and the nearest operating Service hospital.

''(2) EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a

facility if such closure is necessary for medical, environmental, or construction safety reasons.

''(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a health care facility priority system, which shall—

''(i) be developed with Indian Tribes and Tribal Organizations through negotiated rulemaking under section 802;

''(ii) give Indian Tribes' needs the highest priority; and

''(iii) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E).

''(B) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of the Indian Health Care Improvement Act Amendments of 2003 shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as 1 of the 10 top-priority inpatient projects, 1 of the 10 top-pri-

ority outpatient projects, 1 of the 10 top-priority staff quarters developments, or 1 of the 10 top-priority Youth Regional Treatment Centers in the fiscal year 2004 Indian Health Service budget justification, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of the enactment of such Act.

''(2) REPORT; CONTENTS.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, a report which sets forth the following:

''(A) A description of the health care facility priority system of the Service, established under paragraph (1).

''(B) Health care facilities lists, including but not limited to—

''(i) the total health care facilities planning, design, construction, and renovation needs for Indians, identified by national and Service Area priorities;

''(ii) the 10 top-priority inpatient health care facilities;

''(iii) the 10 top-priority outpatient health care facilities;

''(iv) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);

''(v) the 10 top-priority staff quarters developments associated with health care facilities; and

''(vi) the 10 top-priority hostels associated with health care facilities.

''(C) The justification for such order of priority.

''(D) The projected cost of such projects.

''(E) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

''(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing each report required under paragraph (2) (other than the initial report), the Secretary shall annually—

''(A) consult with and obtain information on all health care facilities needs from Indian Tribes, Tribal Organizations, and Urban Indian Organizations; and

''(B) review the total unmet needs of all Indian Tribes and Tribal Organizations for

health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.

''(4) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any Funding Agreement use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(5) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the health care facility priority system.

''(d) REVIEW OF NEED FOR FACILITIES.—

''(1) INITIAL REPORT.—In the year 2005, the General Accounting Office shall prepare and finalize a report which sets forth the needs of the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, for the facilities listed under subsection (c)(2)(B), including the needs for renovation and expansion of existing facilities. The General

Accounting Office shall submit the report to the appropriate authorizing and appropriations committees of the Congress and to the Secretary.

''(2) Beginning in the year 2006, the Secretary shall annually update the report required under paragraph (1).

''(3) The Comptroller General and the Secretary shall consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. In preparing the reports required by paragraphs (1) and (2), the Secretary shall submit the report to the President for inclusion in the report required to be transmitted to the Congress under section 801.

''(4) For purposes of this subsection, the reports shall, regarding the needs of facilities operated under any Funding Agreement be based on the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

''(5) The planning, design, construction, and renovation needs of facilities operated under Funding Agreements shall be fully and equitably integrated into the development of the health facility priority system.

''(6) Beginning in the year 2006 and each fiscal year thereafter, the Secretary shall provide an op-

portunity for nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the health care facility priority system.

''(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

''(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

''SEC. 302. SANITATION FACILITIES.

''(a) FINDINGS.—Congress finds the following:

''(1) The provision of sanitation facilities is primarily a health consideration and function.

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of sanitation facilities.

''(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

''(4) Many Indian homes and Indian communities still lack sanitation facilities.

''(5) It is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with sanitation facilities.

''(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the Secretary, acting through the Service, shall provide the following:

''(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of

the Indian Tribe, Tribal Organization, or Indian community.

''(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the management of utility organizations which operate and maintain sanitation facilities.

''(3) Priority funding for operation and maintenance assistance for, and emergency repairs to, sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

''(c) FUNDING.—Notwithstanding any other provision of law—

''(1) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

''(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and

services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

''(3) unless specifically authorized otherwise when funds are appropriated, the Secretary of Health and Human Services shall use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide additional priority of sanitation facilities assistance to eligible new and existing Indian homes other than the following—

''(A) new homes constructed using housing funds provided by the Department of Housing and Urban Development; and

''(B) existing homes owned or managed by a tribally designated housing entity (as that term is defined in section 4(21) of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103(21)) that were constructed using housing funds provided by the Department of Housing and Urban Development;

''(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into Funding Agreements;

''(5) funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) may be used to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

''(6) funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) may be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

''(7) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned, or appropriated whereby the Department's applicable policies, rules, and regulations shall apply in the implementation of such projects;

''(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act; and

''(9) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards appli-

cable to the planning, design, and construction of sanitation facilities funded under this Act.

''(d) FUNDING PLAN.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall develop and begin implementation of a 10-year funding plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

''(e) CERTAIN CAPABILITIES NOT PREREQUISITE.—The financial and technical capability of an Indian Tribe, Tribal Organization, or Indian community to safely operate, manage, and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(f) FINANCIAL ASSISTANCE.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities.

''(g) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe, Tribal Organization, Indian family, or Indian community has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities.

If a sanitation facility serving a community that is operated by an Indian Tribe, Tribal Organization, or Indian community is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

''(h) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

''(1) any funds appropriated pursuant to this section; and

''(2) any funds appropriated for the purpose of providing sanitation facilities.

''(i) REPORT.—

''(1) REQUIRED; CONTENTS.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, a report which sets forth—

''(A) the current Indian sanitation facility priority system of the Service;

''(B) the methodology for determining sanitation deficiencies;

''(C) the level of initial and final sanitation deficiency for each type of sanitation facility for each project of each Indian Tribe or Indian community; and

''(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (4)(A).

''(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall consult with Indian Tribes and Tribal Organizations to determine the sanitation facility needs of each Indian Tribe. The criteria on which the needs will be evaluated shall be developed through negotiated rulemaking pursuant to section 802.

''(3) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian Tribes and Indian communities.

''(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual, Indian Tribe or Indian community sanitation facility to serve Indian homes are determined as follows:

''(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

''(i) complies with all applicable water supply, pollution control, and solid waste disposal laws; and

''(ii) deficiencies relate to routine replacement, repair, or maintenance needs.

''(B) A level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to—

''(i) small or minor capital improvements needed to bring the facility back into compliance;

''(ii) capital improvements that are necessary to enlarge or improve the facili-

ties in order to meet the current needs for domestic sanitation facilities; or

"(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

"(C) A level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets one or more of the following conditions—

"(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

"(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or

"(iii) there is no access to or no approved or permitted solid waste facility available.

"(D) A level IV deficiency exists if—

"(i) a sanitation facility of an individual, Indian Tribe, Tribal Organization, or Indian community has no piped water or

sewer facilities in the home or the facility has become inoperable due to major component failure; or

''(ii) where only a washeteria or central facility exists in the community.

''(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

''(j) DEFINITIONS.—For purposes of this section, the following terms apply:

''(1) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

''(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

''(a) BUY INDIAN ACT.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act'), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian Tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to regulations adopted pursuant to section 802, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

''(1) ownership and control by Indians;

''(2) equipment;

''(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

''(b) LABOR STANDARDS.—

''(1) IN GENERAL.—For the purposes of implementing the provisions of this title, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act), unless such construction or renovation—

''(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract, compact or funding agreement authorized by the Indian Self-Determination and Education Assistance Act, or other statutory authority; and

''(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal

Organizations to be served by the construction or renovation.

''(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

''SEC. 304. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

''(a) IN GENERAL.—Notwithstanding any other provision of law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization by any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a Funding Agreement, including—

''(1) any plans or designs for such expansion, renovation, or modernization; and

''(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended.

''(b) PRIORITY LIST.—

''(1) IN GENERAL.—The Secretary shall maintain a separate priority list to address the needs for increased operating expenses, personnel, or equipment for such facilities. The methodology for estab-

lishing priorities shall be developed through negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

''(c) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

''(1) the Indian Tribe or Tribal Organization—

''(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and

''(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel, or equipment; and

''(2) the expansion, renovation, or modernization—

''(A) is approved by the appropriate area director of the Service for Federal facilities; and

''(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Sec-

retary with respect to construction or renovation of Service facilities.

''(d) CLOSURE OR CONVERSION OF FACILITIES.—If any Service facility which has been expanded, renovated, or modernized by an Indian Tribe or Tribal Organization under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

''SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

''(a) FUNDING.—

''(1) IN GENERAL.—The Secretary, acting through the Service, in consultation with Indian Tribes and Tribal Organizations, shall make funding

available to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)). Funding made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

''(2) FUNDING AGREEMENT REQUIRED.—Funding under paragraph (1) may only be made available to a Tribal Health Program operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian Tribe or Tribal Organization).

''(b) USE OF FUNDS.—

''(1) ALLOWABLE USES.—Funding provided under this section may be used only for debt reduction or the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 307; and

''(C) which, upon completion of such construction or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually no fewer than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2); and

''(iii) provide ambulatory care in a Service Area (specified in the Funding Agreement) with a population of no fewer than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2).

''(2) USE ONLY FOR CERTAIN PORTION OF COSTS.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C)(ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization ap-

plying for funding under this section whose principal office for health care administration is located on an island or when such office is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

''(c) FUNDING.—

''(1) APPLICATION.—No funding may be made available under this section unless an application or proposal for such funding has been approved by the Secretary in accordance with applicable regulations and has forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

''(A) adequate financial support will be available for the provision of services at such facility;

''(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

''(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

''(2) PRIORITY.—In awarding funding under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

''(A) a need for increased ambulatory care services; and

''(B) insufficient capacity to deliver such services.

''(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed during consultations pursuant to subsection (a)(1).

''(d) REVERSION OF FACILITIES.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.

''(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

''SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

''(a) HEALTH CARE DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, is authorized to enter into Funding Agreements with, or make grants or loan guarantees to, Indian Tribes or Tribal Organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities, including but not limited to hospice, traditional Indian health, and child care facilities.

''(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

''(1) waive any leasing prohibition;

''(2) permit carryover of funds appropriated for the provision of health care services;

''(3) permit the use of other available funds;

''(4) permit the use of funds or property donated from any source for project purposes;

''(5) provide for the reversion of donated real or personal property to the donor; and

''(6) permit the use of Service funds to match other funds, including Federal funds.

''(c) REGULATIONS.—The Secretary shall develop and publish regulations, through rulemaking under section 802, for the review and approval of applications submitted under this section.

''(d) CRITERIA.—The Secretary may enter into a contract or Funding Agreement or award a grant under this section for projects which meet the following criteria:

''(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

''(2) A significant number of Indians, including those with low health status, will be served by the project.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The project is economically viable.

''(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

''(e) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

''(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

''(1) Cass Lake, Minnesota.

''(2) Clinton, Oklahoma.

''(3) Harlem, Montana.

''(4) Mescalero, New Mexico.

''(5) Owyhee, Nevada.

''(6) Parker, Arizona.

''(7) Schurz, Nevada.

''(8) Winnebago, Nebraska.

''(9) Ft. Yuma, California.

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

''(h) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

''(i) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any Funding Agreement, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(j) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a Funding Agreement for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

"SEC. 307. LAND TRANSFER.

''(a) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

''(b) FEDERAL LAND TO THE SERVICE.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

"SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

''The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or ren-

ovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(*l*) of the Indian Self-Determination Act and regulations thereunder. Notwithstanding any other provision of law, such leases, contracts, or other agreements shall be considered as operating leases for the purpose of scoring under the Budget Enforcement Act.

"SEC. 309. LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

"(a) ESTABLISHMENT OF FUND.—There is established in the Treasury of the United States a fund to be known as the Health Care Facilities Loan Fund (hereinafter referred to as the 'HCFLF') to provide to Indian Tribes and Tribal Organizations direct loans, or guarantees for loans, for construction of health care facilities (including but not limited to inpatient facilities, outpatient facilities, staff quarters, hostels, and specialized care facilities such as behavioral health and elder care facilities).

"(b) REGULATIONS; STANDARDS AND PROCEDURES.—The Secretary, acting through the Service, is authorized to issue regulations, developed through rulemaking as set out in section 802, to provide standards and procedures for governing such loans and loan guarantees, subject to the following conditions:

''(1) The principal amount of a loan or loan guarantee may cover 100 percent of eligible costs, including but not limited to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, other facility-related costs and capital purchase (but excluding staffing).

''(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

''(3) In the discretion of the Secretary, the program may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

''(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is shorter.

''(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

''(6) The Secretary may accept an assignment of the revenue of an Indian Tribe or Tribal Organi-

zation as security for any direct loan or loan guarantee under this section.

''(7) In the planning and design of health facilities under this section, users eligible under section 807(c) may be included in any projection of patient population.

''(8) The Secretary shall not collect loan application, processing, or other similar fees from Indian Tribes or Tribal Organizations applying for direct loans or loan guarantees under this section.

''(9) Service funds authorized under loans or loan guarantees in this section shall be eligible for use in matching other Federal funds.

''(c) AMOUNT FOR HCFLF.—

''(1) IN GENERAL.—The HCFLF shall consist of—

''(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated to the fund under paragraph (2);

''(B) such amounts as may be collected from borrowers; and

''(C) all interest earned on amounts in the HCFLF.

''(2) INITIAL FUNDS.—There are authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the HCFLF during the preceding fiscal year and all accrued interest.

''(3) AVAILABLE UNTIL EXPENDED.—All amounts appropriated, collected, or earned relative to the HCFLF shall remain available until expended.

''(4) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the HCFLF as such Secretary determines are not required to meet current withdrawals from the HCFLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at the market price. Any obligation acquired by the fund may be sold by the Secretary of the Treasury at the market price.

''(d) LOANS UNDER ISDEAA.—Amounts in the HCFLF and available pursuant to appropriation Acts may

be expended by the Secretary to make loans under this section to a Tribal Health Program.

''(e) GRANTS TO REPAY LOANS.—The Secretary is authorized to establish a program to provide grants to Indian Tribes and Tribal Organizations for the purpose of repaying all or part of any loan obtained by an Indian Tribe or Tribal Organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, small ambulatory care, staff quarters, and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

''SEC. 310. TRIBAL LEASING.

''A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

''SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease,

in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

''(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project; or

''(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

''(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

''(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

''(2) the Indian Tribe or Tribal Organization meets the need criteria which shall be developed

through the negotiated rulemaking process provided for under section 802.

''(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

''(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

''(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time

within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

''(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

''SEC. 312. LOCATION OF FACILITIES.

''(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

''(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

''(1) all lands within the exterior boundaries of any reservation;

''(2) any lands title to which is held in trust by the United States for the benefit of any Indian

Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian Tribe exercises governmental power; and

''(3) all lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

''SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

''(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

''(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization.

Supportable space allocation shall be defined through the negotiated rulemaking process provided for under section 802.

''(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

''SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

''(a) RENTAL RATES.—

''(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a Funding Agreement shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

''(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

''(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

''(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

''(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

''(b) DIRECT COLLECTION OF RENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

''(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

''(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the mainte-

nance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

''(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

''(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

''(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

''(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

"SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

"(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

"(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

"(c) DEFINITIONS.—For purposes of this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 316. OTHER FUNDING FOR FACILITIES.

''(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into Funding Agreements. Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

''(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

''(c) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

''(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation, developed by rulemaking under section 802, for the planning, design, and construction of health care facilities serving Indians under this Act.

''SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE IV—ACCESS TO HEALTH SERVICES

''SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH CARE PROGRAMS.

''(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian Health Program or by an Urban Indian Organization made under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XXI of

the Social Security Act in preference to an Indian without such coverage.

''(c) USE OF FUNDS.—

''(1) SPECIAL FUND.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of the Social Security Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI of the Social Security Act. Any amounts to be reimbursed that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with Indian Tribes being served by the Service Unit, be used for reducing the health resource deficiencies of the Indian Tribes. In making payments from such fund, the Secretary shall ensure that each Service Unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service Unit makes collections, are entitled by reason of a provision of the Social Security Act.

''(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply upon the election of a Tribal Health Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided during the period of such election.

''(d) DIRECT BILLING.—

''(1) IN GENERAL.—A Tribal Health Program may directly bill for, and receive payment for, health care items and services provided by such Indian tribe or organization for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each Tribal Health Program exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to any other provision of law, but all amounts so reimbursed shall be used by the Tribal Health Program for the purpose of making any improvements in Tribal facilities or Tribal Health Programs that

may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and Tribal Health Programs, any health care-related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to an Indian Tribe or Tribal Organization exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program.

''(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary

to provide for direct billing under a program under a title of the Social Security Act.

''(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''SEC. 402. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into Funding Agreements with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and ad-

ministering programs on or near reservations and trust lands to assist individual Indians—

''(1) to enroll for benefits under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

''(2) to pay premiums for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Tribe or Tribes).

''(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or Funding Agreement which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

''(1) to determine the population of Indians eligible for the benefits described in subsection (a);

''(2) to educate Indians with respect to the benefits available under the respective programs;

''(3) to provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

''(4) to develop and implement methods of improving the participation of Indians in receiving the benefits provided under titles XVIII, XIX, and XXI of the Social Security Act.

''(c) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT PROGRAMS.—

''(1) AGREEMENTS WITH SECRETARY TO IMPROVE RECEIPT AND PROCESSING OF APPLICATIONS.—

''(A) AUTHORIZATION.—The Secretary, acting through the Service, may enter into an agreement with an Indian Tribe, Tribal Organization, or Urban Indian Organization which provides for the receipt and processing of applications by Indians for assistance under titles XIX and XXI of the Social Security Act, and benefits under title XVIII of such Act, by an Indian Health Program or Urban Indian Organization.

''(B) REIMBURSEMENT OF COSTS.—Such agreements may provide for reimbursement of costs of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may, as ap-

propriate, be added to the applicable rate per encounter or be provided as a separate fee-for-service payment to the Indian Tribe or Tribal Organization.

''(C) PROCESSING CLARIFIED.—In this paragraph, the term 'processing' does not include a final determination of eligibility.

''(2) AGREEMENTS WITH STATES FOR OUTREACH ON OR NEAR RESERVATION.—

''(A) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under title XIX or XXI of the Social Security Act, as a condition of continuing approval of a State plan under such title, the State shall take steps as to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with Indian Tribes and Tribal Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are provided.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting

arrangements entered into between States and Indian Tribes and Tribal Organizations for such Indian Tribes and Tribal Organizations to conduct administrative activities under such titles.

''(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

''(e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations in the same manner they apply to grants and Funding Agreements with Indian tribes and Tribal Organizations with respect to programs on or near reservations.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or Funding Agreements made or provided under paragraph (1) requirements that are—

''(A) consistent with the requirements imposed by the Secretary under subsection (b);

''(B) appropriate to Urban Indian Organizations and Urban Indians; and

''(C) necessary to effect the purposes of this section.

''SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed (or, if charges are not billed, the operational, administrative, and other expenses incurred) by the Secretary, an Indian Tribe, or Tribal Organization in providing health services, through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

''(1) such services had been provided by a non-governmental provider; and

''(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

''(2) a no-fault automobile accident insurance plan or program.

''(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

''(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery

provided under subsection (a) shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

''(e) ENFORCEMENT.—

''(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

''(A) intervening or joining in any civil action or proceeding brought—

''(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

''(ii) by any representative or heirs of such individual, or

''(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

''(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

''(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

''(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

''(h) RIGHT OF ACTION AGAINST INSURERS, HMOS, EMPLOYEE BENEFIT PLANS, SELF-INSURANCE PLANS, AND OTHER HEALTH CARE PLANS OR PROGRAMS.—Where an insurance company, health maintenance organization, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program fails or refuses to pay the amount due under subsection (a) for services provided to an individual who is a beneficiary,

participant, or insured of such company, organization, plan, or program, the United States, Indian Tribe, or Tribal Organization shall have a right to assert and pursue all the claims and remedies against such company, organization, plan, or program and against the fiduciaries of such company, organization, plan, or program that the individual could assert or pursue under the terms of the contract, program, or plan or applicable Federal, State, or Tribal law.

''(i) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

''(j) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with re-

spect to populations served by such Indian Tribes and Tribal Organizations.

''(k) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

''(l) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.).

''SEC. 404. CREDITING OF REIMBURSEMENTS.

''(a) USE OF AMOUNTS.—

''(1) RETENTION BY PROGRAM.—Except as provided in section 202(g) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organi-

zation, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

''(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

''(A) Titles XVIII, XIX, and XXI of the Social Security Act.

''(B) This Act, including section 807.

''(C) Public Law 87–693.

''(D) Any other provision of law.

''(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

''SEC. 405. PURCHASING HEALTH CARE COVERAGE.

''(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act, or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Service

beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

''(1) a tribally owned and operated health care plan;

''(2) a State or locally authorized or licensed health care plan;

''(3) a health insurance provider or managed care organization; or

''(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

''(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

"SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

"(a) AUTHORITY.—

"(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

"(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

"(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

"(2) the quality of health care services provided to any Indian through the Service;

''(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

''(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

''(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

''(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

''(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

''SEC. 407. PAYOR OF LAST RESORT.

''Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban In-

dian Organizations, notwithstanding any Federal, State, or local law to the contrary.

"SEC. 408. NONDISCRIMINATION IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

"For purposes of determining the eligibility of an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to receive payment or reimbursement from any federally funded health care program for health care services it furnishes to an Indian, any requirement that the entity be licensed or recognized under State or local law to furnish such services shall be deemed to have been met if the entity meets quality requirements for the furnishing of such services recognized by the Secretary.

"SEC. 409. CONSULTATION.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP (TAG).—

"(1) ESTABLISHMENT AND MEMBERSHIP.—The Secretary shall establish a National Indian Technical Advisory Group (in this subsection referred to as the 'Advisory Group') which shall have no fewer than 14 members including at least 1 member designated by the Indian Tribes and Tribal Organizations in each Service Area, 1 Urban Indian Organization representative, and 1 member representing the Service.

The Secretary may appoint additional members upon the recommendation of the Advisory Group.

''(2) DUTIES.—

''(A) IDENTIFICATION OF ISSUES.—The Advisory Group shall assist the Secretary in identifying and addressing issues regarding the health care programs under the Social Security Act (including medicare, medicaid, and SCHIP) that have implications for Indian Health Programs or Urban Indian Organizations. The Advisory Group shall provide advice to the Secretary with respect to those issues and with respect to the need for the Secretary to engage in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting any requirement under any applicable Executive order for the Secretary to consult with Indian Tribes in cases of health care policies that have implications for Indian Health Programs or Urban Indian Organizations.

''(3) FUNDING.—The Secretary shall pay the expenses of the Advisory Group using the general

administrative funds of the Centers for Medicare & Medicaid Services.

''(4) NONAPPLICATION OF FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Group.

''(5) MEETINGS.—The Secretary shall convene meetings of the Advisory Group no less frequently than quarterly.

''(b) SOLICITATION OF MEDICAID ADVICE.—

''(1) IN GENERAL.—As a requirement for payment under title XIX of the Social Security Act to a State in which the Service operates or funds health care programs or in which 1 or more Indian Health Programs or Urban Indian Organizations provide health care in the State for which medical assistance is available under such title, the State shall establish a process under which the State seeks advice on a regular, ongoing basis (at least on a quarterly basis) from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of such title to such Indian Health Programs and Urban Indian Organizations.

''(2) MANNER OF ADVICE.—Such process shall be in addition to (and not in lieu of) any consultation otherwise required by law and shall apply before the submittal of plan amendments, waiver requests, and proposals for demonstration projects. Such process may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its medicaid plan.

''(3) PAYMENT OF EXPENSES.—Expenses in carrying out this subsection shall be treated as reasonable administrative expenses for which reimbursement may be made under section 1903(a) of the Social Security Act.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding existing advisory committees, working groups, or other advisory procedures established by the Secretary or by any State.

''SEC. 410. STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

''(a) AUTHORIZATION FOR ARRANGEMENTS.—Notwithstanding any other provision of law, insofar as the State health plan of a State under title XXI of the Social Security Act may provide (whether through its medicaid

plan under title XIX of such Act or otherwise) child or other health assistance to individuals who are otherwise served by the Service or by an Indian Tribe or Tribal Organization, the Secretary may enter into an arrangement with the State and with the Service or 1 or more Indian Tribes and Tribal Organizations in the State under which a portion of the funds otherwise made available to the State under such title with respect to such individuals is provided to the Service, Indian Tribe, or Tribal Organization, respectively, for the purpose of providing such assistance to such individuals consistent with the purposes of such title.

''(b) ENTERING INTO ARRANGEMENTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, in the case of a State which has an unexpended allotment amount described in paragraph (2) for a fiscal year, before effecting any reallotment of such amount to other States, at the request of the Service or 1 or more Indian Tribes or Tribal Organizations that operate in the State with respect to individuals who are served by such Service, Indian Tribes, or Tribal Organizations, the Secretary shall enter into an arrangement with the Service, Indian Tribes, or Tribal Organizations under which the Indian child proportion (as defined

in paragraph (3)) for such Service, Indian Tribes, or Tribal Organizations of such unexpended allotment amount is made available to the Service or such Indian Tribes or Tribal Organizations for the purpose of providing child health or other assistance to individuals who are otherwise served by the Service or by such Indian Tribes or Tribal Organizations consistent with the purposes of title XXI of the Social Security Act. Insofar as amounts are made available under the preceding sentence, such amounts shall be treated (for purposes of title XXI of the Social Security Act) as if they had been expended during the period referred to in paragraph (2).

''(2) UNEXPENDED ALLOTMENT AMOUNT.—For purposes of this subsection, the term 'unexpended allotment amount' means, with respect to an allotment to a State under section 2104 of the Social Security Act for a fiscal year, the portion of such allotment which was not expended by the State during the period in which such allotment is available for expenditure by the State and which would, but for this subsection, be realloted to other States.

''(3) INDIAN CHILD PROPORTION.—For purposes of this subsection, the term 'Indian child pro-

portion' means, with respect to an unexpended allotment amount for a State and an arrangement under paragraph (1) with the Service or Indian Tribes or Tribal Organizations, the proportion of targeted low-income children in the State (as defined in section 2110(b) of the Social Security Act) who are Indians who would be served under an arrangement with the Service or such Indian Tribes or Tribal Organizations under such paragraph, as estimated by the Secretary of Health and Human Services based upon the best available data before a portion of the unexpended allotment amount is made available under this subsection.

"SEC. 411. SOCIAL SECURITY ACT SANCTIONS.

"(a) REQUESTS FOR WAIVER OF SANCTIONS.—For purposes of applying any authority under a provision of title XI, XVIII, XIX, or XXI of the Social Security Act to seek a waiver of a sanction imposed against a health care provider insofar as that provider provides services to individuals through an Indian Health Program, any requirement that a State request such a waiver shall be deemed to be met if such Indian Health Program requests such a waiver.

"(b) SAFE HARBOR FOR TRANSACTIONS BETWEEN AND AMONG INDIAN HEALTH CARE PROGRAMS.—For

purposes of applying section 1128B(b) of the Social Security Act, the exchange of anything of value between or among the following shall not be treated as remuneration if the exchange arises from or relates to any of the following health programs:

''(1) An exchange between or among the following:

''(A) Any Indian Health Program.

''(B) Any Urban Indian Organization.

''(2) An exchange between an Indian Tribe, Tribal Organization, or an Urban Indian Organization and any patient served or eligible for service from an Indian Tribe, Tribal Organization, or Urban Indian Organization, including patients served or eligible for service pursuant to section 807, but only if such exchange—

''(A) is for the purpose of transporting the patient for the provision of health care items or services;

''(B) is for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort incidental to assuring the timely provision of health care items and services to the patient;

''(C) is for the purpose of paying premiums, copayments, deductibles, or other cost-sharing on behalf of patients; or

''(D) consists of an item or service of small value that is provided as a reasonable incentive to secure timely and necessary preventive and other items and services.

''(3) Such other exchanges involving an Indian Health Program, an Urban Indian Organization, or an Indian Tribe or Tribal Organization as meet such standards as the Secretary of Health and Human Services, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations and of patients served by Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations.

''SEC. 412. COST SHARING.

''(a) COINSURANCE, COPAYMENTS, AND DEDUCTIBLES.—Notwithstanding any other provision of Federal or State law—

''(1) PROTECTION FOR ELIGIBLE INDIANS UNDER SOCIAL SECURITY ACT HEALTH PROGRAMS.—No Indian who is furnished an item or

service for which payment may be made under title XVIII, XIX, or XXI of the Social Security Act may be charged a deductible, copayment, or coinsurance if the item or service is furnished by, or upon referral made by, the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

''(2) PROTECTION FOR INDIANS.—No Indian who is furnished an item or service by the Service may be charged a deductible, copayment, or coinsurance.

''(3) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—The payment or reimbursement due to the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization under title XVIII, XIX, or XXI of the Social Security Act may not be reduced by the amount of the deductible, copayment, or coinsurance that would be due from the Indian but for the operation of this section.

''(b) EXEMPTION FROM MEDICAID AND SCHIP PREMIUMS.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for services under title XIX of the Social Security Act (relating to the medicaid program) or title XXI of such Act (relating to the State children's health insurance program) may

be charged a premium as a condition of receiving benefits under the program under the respective title.

''(c) MEDICALLY NEEDY PROGRAM SPEND-DOWN.—For the purposes of determining the eligibility of an Indian for medical assistance under any medically needy option under a State's medicaid plan under title XIX of the Social Security Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization shall be deemed to have been an expenditure for health care by the Indian.

''(d) LIMITATION ON MEDICAL CHILD SUPPORT RECOVERY.—Notwithstanding any other provision of law, a parent (whether or not an Indian) of an Indian child shall not be responsible for reimbursing a State or the Federal Government under title XIX or XXI of the Social Security Act for the cost of medical services relating to the child (including childbirth and including, where such child is a minor parent, any child of such minor parent) under circumstances in which payment would have been made under the contract health services program of an Indian Health Program but for the child's (or, in the case of medical services relating to childbirth, mother's, or grandchild's, as the case may be) eligibility under title XIX or XXI of the Social Security Act.

''(e) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID ELIGIBILITY.—Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services under title XIX of the Social Security Act:

''(1) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State, or Tribal law or custom from recourse and including public domain allotments.

''(2) Property that has unique religious or cultural significance or that supports subsistence or traditional lifestyle according to applicable Tribal law or custom.

''(f) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Income, resources, and property that are exempt from medicaid estate recovery under title XIX of the Social Security Act as of April 1, 2003, under manual instructions issued to carry out section 1917(b)(3) of such Act because of Federal responsibility for Indian Tribes and Alaska Native Villages shall remain so exempt. Nothing in this subsection shall be construed as preventing the Secretary from providing additional medicaid estate recovery exemptions for Indians.

"SEC. 413. TREATMENT UNDER MEDICAID MANAGED CARE.

"(a) PAYMENT FOR SERVICES FURNISHED TO INDIANS.—In the case of an Indian who is enrolled with a managed care entity under section 1932 of the Social Security Act (or otherwise under a waiver under title XIX of such Act) and who receives covered services from an Indian Health Program or an Urban Indian Organization, either—

"(1) the entity shall make payment to the Indian Health Program or Urban Indian Organization at a rate established by the entity for such services that is not less than the rate for preferred providers (or at such other rate as may be negotiated between the entity and such Indian Health Program or Urban Indian Organization) and shall not require submittal of a claim by the enrollee as a condition of payment to the Indian Health Program or Urban Indian Organization; or

"(2) the State shall provide for payment to the Indian Health Program or Urban Indian Organization under its State plan under title XIX of such Act at the rate otherwise applicable and shall provide for an appropriate adjustment of the capitation payment made to the entity to take into account such payment.

"(b) OFFERING OF MANAGED CARE.—If—

''(1) a State elects under its State plan under title XIX of the Social Security Act to provide services through medicaid managed care organizations or through primary care case managers under section 1932 or under a waiver under such title; and

''(2) the Indian Health Program or Urban Indian Organization that is funded in whole or in part by the Service, or a consortium thereof, has established a medicaid managed care organization or a primary care case manager that meets quality standards equivalent to those required of such an organization or manager under such section or waiver,

the State shall enter into an agreement under such section with the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization, or such consortium, to serve as a medicaid managed care organization or a primary care case manager, respectively with respect to Indians served by such entity. In carrying out this subsection, the Secretary and the State may waive requirements regarding enrollment, capitalization, and such other matters that might otherwise prevent the application of the previous sentence.

''SEC. 414. NAVAJO NATION MEDICAID AGENCY.

''(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to treat the Nav-

ajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation.

''(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures for the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act and related administrative funds under such title, which are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

''(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other single State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

''(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such

Nation, include Western and traditional Navajo healing services) within the Navajo Nation.

''(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per centum with respect to amounts the Navajo Nation Medicaid Agency expends for medical assistance for services and for related administrative costs.

''(f) DEMONSTRATION FUNDING.—The Secretary is further authorized to assist the Navajo Nation by providing funding including demonstration grant funding for this project.

''(g) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of title XIX of the Social Security Act to establish, develop, and implement the Navajo Nation Medicaid Agency.

''(h) OPTIONAL APPLICATION TO SCHIP.—In the option of the Navajo Nation, the Secretary is authorized to treat the Navajo Nation as a State for the purposes of title XXI of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in subsections (a) through (g).

''SEC. 415. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

''SEC. 501. PURPOSE.

''The purpose of this title is to establish programs in Urban Centers to make health services more accessible and available to Urban Indians.

''SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, Urban Indian Organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title. Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any Urban Indian Organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

''(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, Urban Indian Organizations for the provision of health care and referral services for Urban Indians. Any such contract or grant shall include requirements that the Urban Indian Organization successfully undertake to—

''(1) estimate the population of Urban Indians residing in the Urban Center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

''(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

''(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

''(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

''(5) make recommendations to the Secretary and Federal, State, local, and other resource agen-

cies on methods of improving health service programs to meet the needs of Urban Indians; and

''(6) where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.

''(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting Urban Indian Organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of Urban Indians in the Urban Center or centers involved;

''(2) the size of the Urban Indian population in the Urban Center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

''(4) the capability of an Urban Indian Organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

''(5) the satisfactory performance and successful completion by an Urban Indian Organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and

''(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

''(e) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health promotion and disease prevention services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under this section.

''(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) MENTAL HEALTH SERVICES.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).

''(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment of the following:

''(A) The mental health needs of the Urban Indian population concerned.

''(B) The mental health services and other related resources available to that population.

''(C) The barriers to obtaining those services and resources.

''(D) The needs that are unmet by such services and resources.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

''(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.

''(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) PREVENTION OF CHILD ABUSE.—

''(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians through grants to Urban Indian Organizations administering contracts entered into or receiving

grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

''(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the Urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

''(A) To prepare assessments required under paragraph (2).

''(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.

"(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to Urban Indian perpetrators of child abuse (including sexual abuse).

"(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the Urban Indian Organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

"(B) the capability and expertise demonstrated by the Urban Indian Organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

''(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

''SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

''(a) GRANTS AND CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with or make grants to Urban Indian Organizations situated in Urban Centers for which contracts have not been entered into or grants have not been made under section 503.

''(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the Urban Indian Organization which the Secretary has

entered into a contract with, or made a grant to, under this section.

''(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the Urban Indian Organization successfully undertakes to—

''(A) document the health care status and unmet health care needs of Urban Indians in the Urban Center involved; and

''(B) with respect to Urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

''(2) the Urban Indian Organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and compliance with and performance of contracts entered into by Urban Indian Organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, in determining the capacity of an Urban Indian Organization to deliver quality patient care the Secretary shall, at the option of the organization—

"(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

"(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

"(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under

this section, the Secretary determines that an Urban Indian Organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the organization the areas of noncompliance or unsatisfactory performance and modify the contract or grant to prevent future occurrences of noncompliance or unsatisfactory performance. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew the contract or grant with the organization and is authorized to enter into a contract or make a grant under section 503 with another Urban Indian Organization which is situated in the same Urban Center as the Urban Indian Organization whose contract or grant is not renewed under this section.

''(d) CONSIDERATIONS FOR RENEWALS.—In determining whether to renew a contract or grant with an Urban Indian Organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the Urban Indian Organization, the reports submitted under section 507, and shall consider the results of the onsite evaluations or accreditations under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

''(a) PROCUREMENT.—Contracts with Urban Indian Organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections 1304, 3131, and 3133 of title 40, United States Code.

''(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

''(1) be made in their entirety by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

''(2) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent

funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

''(c) REVISION OR AMENDMENT OF CONTRACTS.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an Urban Indian Organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM SERVICES AND ASSISTANCE.—Contracts with or grants to Urban Indian Organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to Urban Indians of services and assistance under such contracts or grants by such organizations.

''SEC. 507. REPORTS AND RECORDS.

''(a) REPORTS.—For each fiscal year during which an Urban Indian Organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, such Urban Indian Organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

''(1) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

''(2) Information on activities conducted by the organization pursuant to the contract or grant.

''(3) An accounting of the amounts and purpose for which Federal funds were expended.

''(4) A minimum set of data, using uniformly defined elements, that is specified by the Secretary in consultation, consistent with section 514, with Urban Indian Organizations.

''(b) AUDIT.—The reports and records of the Urban Indian Organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COSTS OF AUDITS.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

''SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

''The authority of the Secretary to enter into contracts or to award grants under this title shall be to the

extent, and in an amount, provided for in appropriation Acts.

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide to contractors or grant recipients under this title loans from the Urban Indian Health Care Facilities Revolving Loan Fund described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

"(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

''(2) The total of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

''(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility or 25 years.

''(4) An Urban Indian Organization may assign, and the Secretary may accept assignment of, the revenue of the Urban Indian Organization as security for a loan or loan guarantee under this subsection.

''(5) The Secretary shall not collect application, processing, or similar fees from Urban Indian Organizations applying for loans or loan guarantees under this subsection.

''(c) FUND.—

''(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund (hereafter in this section referred to as the ''URLF''). The URLF shall consist of—

''(A) such amounts as may be appropriated to the URLF;

''(B) amounts received from Urban Indian Organizations in repayment of loans made to such organizations under paragraph (2); and

''(C) interest earned on amounts in the URLF under paragraph (3).

''(2) USE OF AMOUNT IN FUND.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to Urban Indian Organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from Urban Indian Organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

''(3) INVESTMENT OF AMOUNTS IN FUND.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at the market price. Any ob-

ligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

''(4) INITIAL FUNDS.—There are authorized to be appropriated such sums as may be necessary to initiate the URLF. For each fiscal year after the initial year in which funds are appropriated to the URLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the URLF during the preceding fiscal year and all accrued interest.

''SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

''There is hereby established within the Service an Office of Urban Indian Health, which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to Urban Indian Organizations.

''SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

''(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based edu-

cation regarding, alcohol and substance abuse in Urban Centers to those Urban Indian Organizations with which the Secretary has entered into a contract under this title or under section 201.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

''(1) The size of the Urban Indian population.

''(2) Capability of the organization to adequately perform the activities required under the grant.

''(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. The standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.

''(4) Identification of the need for services.

''(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on the criteria established pursuant to subsection (c).

''(e) GRANTS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

''SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

''(1) be permanent programs within the Service's direct care program;

''(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and

''(3) shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.

''SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, through the Office of Urban Indian Health, shall make grants or enter into contracts with Urban Indian Organizations for the administration of Urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (here-

after in this section referred to as 'NIAAA') and transferred to the Service. Such grants and contracts shall become effective no later than September 30, 2004.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for Urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian Organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities of programs funded under this section not less than every 5 years.

''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service, the Centers for Medicare & Medicaid Services, and other operating divisions and staff divisions of the Department consult, to the greatest extent practicable, with Urban Indian Organizations prior to taking any action, or approving Federal financial assistance for any action

of a State, that may affect Urban Indians or Urban Indian Organizations.

''(b) DEFINITION OF CONSULTATION.—For purposes of subsection (a), consultation is the open and free exchange of information and opinion among Urban Indian Organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

''SEC. 515. FEDERAL TORT CLAIM ACT COVERAGE.

''(a) IN GENERAL.—With respect to claims resulting from the performance of functions during fiscal year 2004 and thereafter, or claims asserted after September 30, 2003, but resulting from the performance of functions prior to fiscal year 2004, under a contract, grant agreement, or any other agreement authorized under this title, an Urban Indian Organization is deemed hereafter to be part of the Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement. After September 30, 2003, any civil action or proceeding involving such claims brought hereafter against any Urban Indian Organization or any employee of such Urban Indian Organiza-

tion covered by this provision shall be deemed to be an action against the United States and will be defended by the Attorney General and be afforded the full protection and coverage of the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.).

''(b) CLAIMS RESULTING FROM PERFORMANCE OF CONTRACT OR GRANT.—Beginning with the fiscal year ending September 30, 2003, and thereafter, the appropriate Secretary shall request through annual appropriations funds sufficient to reimburse the Treasury for any claims paid in the prior fiscal year pursuant to the foregoing provisions.

''(c) EFFECT ON ISDEAA.—Nothing in this section shall in any way affect the provisions of section 102(d) of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450f(d)).

''SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

''(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, through grant or contract, shall make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to

Urban Indian youth in a culturally competent residential setting.

''(b) DEFINITION OF STATE.—A State described in this subsection is a State in which—

''(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

''(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

''SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) AUTHORIZATION FOR USE.—The Secretary, acting through the Service, shall allow an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined

to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

''(c) ACQUISITION OF PROPERTY FOR DONATION.—The Secretary may acquire excess or surplus government personal or real property for donation (subject to subsection (d)), to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the Urban Indian Organization for a purpose for which a contract or grant is authorized under this title.

''(d) PRIORITY.—In the event that the Secretary receives a request for donation of a specific item of personal or real property described in subsection (b) or (c) from both an Urban Indian Organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation of the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically to the Urban Indian Organization.

''(e) URBAN INDIAN ORGANIZATIONS DEEMED EXECUTIVE AGENCY FOR CERTAIN PURPOSES.—For pur-

poses of section 501 of title 40, United States Code, (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the Urban Indian Organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

''(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

''(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

''(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to the following:

''(1) The size and location of the Urban Indian population to be served.

''(2) The need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served.

''(3) Performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee.

''(4) The capability of the organization to adequately perform the activities required under the grant.

''(5) The willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

''(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

''SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban In-

dian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.

''SEC. 520. REGULATIONS.

''(a) REQUIREMENTS FOR REGULATIONS.—The Secretary may promulgate regulations to implement the provisions of this title in accordance with the following:

''(1) Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 9 months after the date of the enactment of this Act and shall have no less than a 4-month comment period.

''(2) The authority to promulgate regulations under this Act shall expire 18 months from the date of the enactment of this Act.

''(b) EFFECTIVE DATE OF TITLE.—The amendments to this title made by the Indian Health Care Improvement Act Amendments of 2003 shall be effective on the date of the enactment of such amendments, regardless of whether the Secretary has promulgated regulations implementing such amendments have been promulgated.

''SEC. 521. ELIGIBILITY FOR SERVICES.

''Urban Indians shall be eligible for health care or referral services provided pursuant to this title.

''SEC. 522. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE VI—ORGANIZATIONAL IMPROVEMENTS

''SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services provided under Federal statute or treaties to Indians and Indian Tribes, there was established within the Public Health Service of the Department the Indian Health Service.

''(b) DIRECTOR.—The Indian Health Service is an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health

Service shall report to the Secretary through the Assistant Secretary for Health of the Department of Health and Human Services. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

''(c) DUTIES.—The Secretary shall carry out through the Director of the Indian Health Service—

''(1) all functions which were, on the day before the date of the enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

''(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and use of, health services for Indians;

''(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including but not limited to programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.); and

''(4) all scholarship and loan functions carried out under title I.

''(d) AUTHORITIES.—(1) The Director shall have the authority—

''(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

''(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

''(C) to manage, expend, and obligate all funds appropriated for the Service.

''(2) Notwithstanding any other law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

''(a)(1) The Secretary shall establish an automated management information system for the Service.

''(2) The information system established under paragraph (1) shall include—

''(A) a financial management system;

''(B) a patient care information system for each area served by the Service;

''(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service;

''(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area Office of the Service;

''(E) an interface mechanism for patient billing and accounts receivable system; and

''(F) a training component.

''(b) The Secretary shall provide each Tribal Health Program automated management information systems which—

''(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

''(d) The Director shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

''SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—The purposes of this section are as follows:

''(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavioral health prevention

and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

''(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

''(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

''(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

''(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

''(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

''(b) PLANS.—

''(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

''(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

''(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

''(ii) an estimate of the financial and human cost attributable to such illness or behavior.

''(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

''(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

''(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

''(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

''(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient/day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

''(G) emergency shelter;

''(H) intensive case management; and

''(I) Traditional Health Care Practices.

''(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including the following:

''(A) Preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention.

''(B) Mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco).

''(C) Identification and treatment of co-occurring disorders and comorbidity.

''(D) Prevention of alcohol, drug, inhalant, and tobacco use.

''(E) Early intervention, treatment, and aftercare.

''(F) Promotion of healthy choices and lifestyle (related to sexually transmitted diseases, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk/safety issues).

''(G) Identification and treatment of neglect and physical, mental, and sexual abuse.

''(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including the following:

''(A) Early intervention, treatment, and aftercare.

''(B) Mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services.

''(C) Identification and treatment of co-occurring disorders (dual diagnosis) and co-morbidity.

''(D) Promotion of gender specific healthy choices and lifestyle (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk-related behavior).

''(E) Treatment services for women at risk of giving birth to a child with a fetal alcohol disorder.

''(F) Gender specific treatment for sexual assault and domestic violence.

''(4) FAMILY CARE.—Behavioral health services for families, including the following:

''(A) Early intervention, treatment, and aftercare for affected families.

''(B) Treatment for sexual assault and domestic violence.

''(C) Promotion of healthy choices and lifestyle (related to parenting, partners, domestic violence, and other abuse issues).

''(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including the following:

''(A) Early intervention, treatment, and aftercare.

''(B) Mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services.

''(C) Identification and treatment of co-occurring disorders (dual diagnosis) and co-morbidity.

''(D) Promotion of healthy choices and lifestyle (managing conditions related to aging).

''(E) Gender specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation.

''(F) Identification and treatment of dementias regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, pre-

vent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

''(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State

agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

''(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

''SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

''(a) CONTENTS.—Not later than 12 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

''(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

''(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians.

''(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

''(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to mental health services to which all citizens have access.

''(B) The right of Indians to participate in, and receive the benefit of, such services.

''(C) The actions necessary to protect the exercise of such right.

''(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

"(6) A strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring mental health and substance abuse treatment; and

"(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

"(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to commu-

nity behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

''(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

''(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alco-

hol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary, acting through the Service, and the Secretary of the Interior shall, in developing the memoranda of agreement under subsection (a), consult with and solicit the comments from—

''(1) Indian Tribes and Tribal Organizations;

''(2) Indians;

''(3) Urban Indian Organizations and other Indian organizations; and

''(4) behavioral health service providers.

''(d) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide a program of comprehensive

behavioral health, prevention, treatment, and aftercare, including Traditional Health Care Practices, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification, psychiatric hospitalization, and residential and intensive outpatient treatment;

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

''(E) specialized residential treatment programs for high-risk populations, including but not limited to pregnant and postpartum women and their children.

''(2) TARGET POPULATIONS.—The target population of such program shall be members of Indian Tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

''(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

''SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a mental health technician program within the Service which—

''(1) provides for the training of Indians as mental health technicians; and

''(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

''(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall supervise and evaluate the mental health technicians in the training program.

''(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served.

''SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''Subject to the provisions of section 221, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health

care services to Indians in a clinical setting under this Act or through a Funding Agreement shall, in the case of a person employed as a psychologist, social worker, or marriage and family therapist, be licensed as a clinical psychologist, social worker, or marriage and family therapist, respectively, or working under the direct supervision of a licensed clinical psychologist, social worker, or marriage and family therapist, respectively.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) FUNDING.—The Secretary, consistent with section 701, shall make funds available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF FUNDS.—Funds made available pursuant to this section may be used to—

''(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

''(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

''(3) develop prevention and intervention models for Indian women which incorporate Traditional Health Care Practices, cultural values, and community and family involvement.

''(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

''(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations.

''SEC. 707. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian

Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

''(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section

4(*l*) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(*l*)).

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in such State.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate Traditional Health Care Practices, to Indian children and adolescents, including—

''(A) pretreatment assistance;

''(B) inpatient, outpatient, and aftercare services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) for intensive home- and community-based services.

''(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the

review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall—

''(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

''(B) establish guidelines, in consultation with Indian Tribes and Tribal Organizations, for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian Tribe or Tribal Organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide for the inclusion of family mem-

bers of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including, but not limited to, alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

''SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

''Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with be-

havioral health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

''(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or provide funding for Indian Tribes and Tribal Organizations to develop and implement, within each Service Unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, Tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Community-based training (oriented toward local capacity development) shall also include tribal community provider training (designed for adult

learners from the communities receiving services for prevention, intervention, treatment, and aftercare).

''(b) INSTRUCTION.—The Secretary, acting through the Service, shall, either directly or through Indian Tribes and Tribal Organizations, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

''SEC. 710. BEHAVIORAL HEALTH PROGRAM.

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) FUNDING; CRITERIA.—The Secretary may award such funding for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

''(1) The project will address significant unmet behavioral health needs among Indians.

''(2) The project will serve a significant number of Indians.

''(3) The project has the potential to deliver services in an efficient and effective manner.

''(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(5) The project may deliver services in a manner consistent with Traditional Health Care Practices.

''(6) The project is coordinated with, and avoids duplication of, existing services.

''(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any Funding Agreement, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

''SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 701, acting through Indian Tribes and Tribal Organizations, shall establish and operate fetal alcohol disorder programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

''(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(A) To develop and provide for Indians community and in school training, education, and prevention programs relating to fetal alcohol disorders.

"(B) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

"(C) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected Indians and their families or caretakers.

"(D) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

"(E) To develop prevention and intervention models which incorporate practitioners of Traditional Health Care Practices, cultural and spiritual values, and community involvement.

"(F) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

"(G) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

''(H) To develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

''(I) To develop and fund community-based adult fetal alcohol disorder housing and support services for Indians and for women pregnant with an Indian's child.

''(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) SERVICES.—The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities; and

''(2) provide supportive services, directly or through an Indian Tribe, Tribal Organization, or Urban Indian Organization, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

''(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

''(1) The National Institute on Drug Abuse.

''(2) The National Institute on Alcohol and Alcoholism.

''(3) The Office of Substance Abuse Prevention.

''(4) The National Institute of Mental Health.

''(5) The Service.

''(6) The Office of Minority Health of the Department of Health and Human Services.

''(7) The Administration for Native Americans.

''(8) The National Institute of Child Health and Human Development (NICHD).

''(9) The Centers for Disease Control and Prevention.

''(10) The Bureau of Indian Affairs.

''(11) Indian Tribes.

''(12) Tribal Organizations.

''(13) Urban Indian Organizations.

''(14) Indian fetal alcohol disorder experts.

''(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental

Health Services Administration, shall make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and Urban Indians affected by fetal alcohol disorder.

''(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations funded under title V.

''SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

''(1) victims of sexual abuse who are Indian children or children in an Indian household; and

''(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

''(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

''(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

''(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

''(3) To develop prevention and intervention models which incorporate Traditional Health Care Practices, cultural and spiritual values, and community involvement.

''(4) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

''(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

''(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

''(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

''SEC. 713. BEHAVIORAL HEALTH RESEARCH.

''The Secretary, in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(2) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"For the purpose of this title, the following definitions shall apply:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

"(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. This can include the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(4) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources a as community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers (mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, ministers, etc.)

''(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

''(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syn-

drome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

''(7) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

''(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

''(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(C) Prenatal or postnatal growth delay.

''(8) PARTIAL FAS.—The term 'partial FAS' means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

''(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.

''(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out the provisions of this title.

''TITLE VIII—MISCELLANEOUS

''SEC. 801. REPORTS.

''The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to Congress a report containing the following:

''(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population, including specific comparisons of appropriations provided and those required for such parity.

''(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 808.

''(3) A report on the use of health services by Indians—

''(A) on a national and area or other relevant geographical basis;

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) on the services provided under Funding Agreements.

''(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

''(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

''(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 126(f).

''(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

''(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

''(9) A biennial report to Congress on infectious diseases as required by section 212.

''(10) A report on environmental and nuclear health hazards as required by section 215.

''(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2) and 301(d).

''(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(i).

''(13) An annual report on the expenditure of nonservice funds for renovation as required by sections 304(b)(2).

''(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

''(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

''(16) A report on any arrangements for the sharing of medical facilities or services between the Service, Indian Tribes, and Tribal Organizations, and the Department of Veterans Affairs and the Department of Defense, as authorized by section 406.

''(17) A report on evaluation and renewal of Urban Indian programs under section 505.

''(18) A report on the evaluation of programs as required by section 513(d).

''(19) A report on alcohol and substance abuse as required by section 701(f).

''SEC. 802. REGULATIONS.

''(a) DEADLINES.—

''(1) PROCEDURES.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to

negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles I, II, III, IV, and VII and section 817. The Secretary may promulgate regulations to carry out sections 105, 115, 117, and title V, using the procedures required by the Administrative Procedures Act. The Secretary shall issue no regulations to carry out titles VI and VIII, except as necessary to carry out section 817.

''(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 270 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003 and shall have no less than a 120-day comment period.

''(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of the enactment of this Act.

''(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes and Tribal Organiza-

tions, a majority of whom shall be nominated by and be representatives of Indian Tribes, Tribal Organizations, and Urban Indian Organizations from each Service Area.

''(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

''(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''Not later than 8 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule (including a schedule of appropriation

requests), by title and section, by which the Secretary will implement the provisions of this Act.

''SEC. 804. AVAILABILITY OF FUNDS.

''The funds appropriated pursuant to this Act shall remain available until expended.

''SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

''Any limitation on the use of funds contained in an Act providing appropriations for the Department for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

''SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) IN GENERAL.—The following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a federally recognized Indian Tribe.

''(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

''(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

''SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) CHILDREN.—Any individual who—

''(1) has not attained 19 years of age;

''(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

''(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs

of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

''(b) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of the Indian Tribe(s) being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(c) PROVISION OF SERVICES TO OTHER INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service

Unit and who are not otherwise eligible for such health services if—

''(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

''(B) the Secretary and the served Indian Tribes have jointly determined that—

''(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

''(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

''(2) ISDEAA PROGRAMS.—In the case of a Tribal Health Program, the governing body of the Indian Tribe or Tribal Organization providing health services under such Tribal Health Program is authorized to determine whether health services should be provided under its Funding Agreement to individuals who are not otherwise eligible for such services. In making such determination, the governing body shall take into account the considerations described in clauses (i) and (ii) of paragraph (1)(B).

"(3) PAYMENT FOR SERVICES.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service under of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 404 of this Act, or any other provision of law, amounts collected under this subsection, including medicare, medicaid, or SCHIP reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

"(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of

paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent individual.

''(4) REVOCATION OF CONSENT FOR SERVICES.—

''(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian Tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian Tribe revokes its concurrence to the provision of such health services.

''(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian Tribes in the Service Area revoke their concurrence to the provisions of such health services.

''(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or

''(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible individual.

''(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—Hospital privileges in health facilities operated and maintained by the Service or operated under a Funding Agreement may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible

persons as a part of the conditions under which such hospital privileges are extended.

''(f) ELIGIBLE INDIAN.—For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

''SEC. 808. REALLOCATION OF BASE RESOURCES.

''(a) REPORT REQUIRED.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be implemented only after the Secretary has submitted to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) EXCEPTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is at least 5 percent less than the amount appropriated to the Service for the previous fiscal year.

''SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and Urban Indian

Organizations of the findings and results of demonstration projects conducted under this Act.

"SEC. 810. PROVISION OF SERVICES IN MONTANA.

"(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

"(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the Public Health Service, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until

such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a Funding Agreement shall not be considered an 'employer'.

"SEC. 813. PRIME VENDOR.

"(a) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), a Tribal Health Program shall be deemed an executive agency when carrying out a contract, grant, cooperative agreement, or Funding Agreement with the Service and shall have access to the Federal Supply Schedule and any other Federal source of supply to which executive agencies have access.

"(b) HHS STATUS.—For purposes of section 4 of Public Law 102–585 (38 U.S.C. 8126), a Tribal Health Program shall have the status of the Indian Health Service and shall have direct access to the Veterans Administration prime vendor provided for in section 4 of Public Law 102–585.

''(c) EMPLOYEE STATUS.—The employees of such Tribal Health Programs may order supplies under such respective programs on the same basis as employees of the Service.

''SEC. 814. SEVERABILITY PROVISIONS.

''If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

''SEC. 815. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

''(a) ESTABLISHMENT.—There is hereby established the National Bipartisan Indian Health Care Entitlement Commission (the 'Commission').

''(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

''(1) To establish a study committee composed of those members of the Commission appointed by the Director and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

''(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

''(B) To make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which will address, among other things, issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provided and the cost, including mechanisms for making funds available for the health services to be provided.

''(C) To determine the effect of the enactment of such recommendations on (i) the exist-

ing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

''(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

''(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

''(2) To review and analyze the recommendations of the report of the study committee.

''(3) To make recommendations to Congress for providing health services for Indians as an entitlement, giving due regard to the effects of such a program on existing health care delivery systems for In-

dians and the effect of such a program on the sovereign status of Indian Tribes.

''(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress containing a recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian Tribes.

''(c) MEMBERS.—

''(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

''(A) Ten members of Congress, including 3 from the United States House of Representatives and 2 from the United States Senate, appointed by their respective majority leaders, and 3 from the United States House of Representatives and 2 from the United States Senate, appointed by their respective minority leaders, and who shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

"(B) Twelve persons chosen by the Congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

"(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least one of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

"(D) All those persons chosen by the Congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

''(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the Congressional members of the Commission.

''(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

''(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the Congressional members.

''(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(d) COMPENSATION.—

''(1) CONGRESSIONAL MEMBERS.—Each Congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(e) MEETINGS.—The Commission shall meet at the call of the Chair.

''(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

''(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

''(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commis-

sion. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

''(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

''(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

''(h) HEARINGS.—(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count towards the number of regional hearings required by this subsection.

''(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

''(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare and Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

''(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

''(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

''(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

''(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under

section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

''(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

''(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriation for health care for Indian persons.

''(j) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

''SEC. 816. APPROPRIATIONS; AVAILABILITY.

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"SEC. 817. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS: QUALIFIED IMMUNITY FOR PARTICIPANTS.

''(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

''(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

''(1) No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

''(2) A person who reviews or creates medical quality assurance records for any Indian health program or who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in

connection with such records except as provided in this section.

''(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

''(1) Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

''(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

''(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

''(C) To a governmental board or agency or to a professional health care society or orga-

nization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

''(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

''(E) To an officer, employee, or contractor of any Indian Health Program or Urban Indian Organization who has a need for such record or testimony to perform official duties.

''(F) To a criminal or civil law enforcement agency or instrumentality charged under

applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

''(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

''(2) With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization. Such requirement does not apply to the release of information pursuant to section 552a of title 5.

''(d) DISCLOSURE FOR CERTAIN PURPOSES.—

''(1) Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations's medical quality assurance programs.

''(2) Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the General Accounting Office if such record pertains to any matter within their respective jurisdictions.

''(e) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—A person or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

''(f) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5.

''(g) LIMITATION ON CIVIL LIABILITY.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance

records described in subsection (a) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

''(h) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

''(i) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802 of this title.

''(j) DEFINITIONS.—In this section:

''(1) The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other re-

view bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

''(2) The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (1) and are produced or compiled by an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

''(3) The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

"SEC. 818. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.''.

SEC. 3. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following new section:

''SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).''.

SEC. 4. AMENDMENTS TO MEDICARE PROGRAM.

(a) EXPANSION OF MEDICARE PAYMENT FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

''INDIAN HEALTH PROGRAMS'';

(B) by amending subsection (a) to read as follows:

''(a) An Indian Health Program (as that term is defined in section 4 of the Indian Health Care Improvement Act) shall be eligible for payments under this title, notwithstanding sections 1814(e) and 1835(d), with respect to covered items and services it furnishes if (subject to section 408 of such Act) it meets the conditions and requirements for such payments which apply to the furnishing of such items and services under this title.''; and

(C) by striking subsection (e).

(2) ELIMINATION OF TEMPORARY DEEMING PROVISION, SEPARATE FUND REQUIREMENT, AND DUPLICATIVE ANNUAL REPORT.—Such section is amended by striking subsections (b) through (d).

(3) REFERENCE CORRECTION.—Subsection (f) of such section is redesignated as subsection (b) and is amended by striking ''section 405'' and inserting ''section 401(d)''.

(b) LIMITATION ON CHARGES FOR HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.—

(1) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(T) in the case of hospitals and critical access hospitals which furnish services for which payment may be made under this title to be a participating provider—

"(i) under the contract health services program operated by an Indian Health Program (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under and furnished to an individual eligible for such program; and

"(ii) under a program funded by the Indian Health Service and operated by an Urban Indian Organization with respect to the purchase of items and services for an eligible Urban Indian (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603); in accordance with regulations promulgated by the Secretary regarding admission practices,

payment methodology, and rates of payment (including the acceptance of not more than such payment rate as payment in full for such items and services).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of the enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

(c) MEDICARE COVERAGE OF SERVICES OF COMMUNITY HEALTH AIDES OR PRACTITIONERS.—

(1) IN GENERAL.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)(K)—

(i) in clause (ii), by adding ''and'' at the end; and

(ii) by adding at the end the following new clause:

''(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a community health aide or practitioner which the aide or practitioner is legally authorized to perform, and

such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service but only if no other provider charges or is paid any amounts with respect to the professional fee for furnishing of such services (and, in the case of a telehealth service described in section 1834(m), treating services at the originating site and the distant site as separate services);''; and

(B) by adding at the end the following new subsection:

''Community Health Aides or Practitioners

''(ww) The term 'community health aides or practitioner' means such an aide or practitioner who has been certified under the provisions of section 121 of the Indian Health Care Improvement Act and who only provides services as an employee of the Indian Health Service, an Indian Tribe, or Tribal Organization.''.

(2) PAYMENT.—

(A) PAYMENT RATE.—Section 1833(a)(1)(O) of such Act (42 U.S.C. 1395l(a)(1)(O)) is amended—

(i) by striking ''or'' before ''(ii)''; and

(ii) by adding at the end the following: ''or (iii) in the case of services of a

community health aide or practitioner, the lesser of the actual charge or 80 percent of the fee schedule amount provided under section 1848,''.

(B) LIMITATION ON BALANCE BILLING.—Section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A community health aide or practitioner.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2004.

(d) CONTINUATION OF SPECIAL TREATMENT FOR COLLABORATIVE ARRANGEMENTS BETWEEN INDIAN HEALTH PROGRAMS AND HOSPITAL OUTPATIENT DEPARTMENTS.—Section 1833(t)(13) of the Social Security Act (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

''(B) EXTENSION OF TREATMENT OF CERTAIN COLLABORATIVE ARRANGEMENTS.—With respect to the treatment under this subsection of collaborative arrangements between a health program operated by the Indian Health Service, an Indian Tribe, or Tribal Organization and a

hospital operated by such Service or such an Indian Tribe or Tribal Organization, the Secretary shall reinstate treatment (as in effect on January 1, 2000) and extend it to such collaborative arrangements regardless of when they were entered into.''.

(e) COVERAGE OF VISITING NURSE SERVICES OF TRIBAL CLINICS.—

(1) IN GENERAL.—Section 1861(aa)(1) of the Social Security Act (42 U.S.C. 1395x(aa)(1)) is amended by adding at the end the following:

''For purposes of applying subparagraph (C) (relating to visiting nurse services), an ambulatory care clinic or other outpatient program of the Indian Health Service or of an Indian Tribe or a Tribal Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) shall be treated as if it were a rural health clinic located in an area described in such subparagraph, and nursing care and supplies described in such subparagraph and furnished to an individual as an outpatient of such a tribal clinic or program shall be reimbursable under this title using the methodology specified in section 4(f) of the Indian Health Care Improvement Act Amendments of 2003, and, for purposes of this sentence, any reference

in such subparagraph (C) to a licensed practical nurse is also deemed to include a reference to a home health aide.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply services furnished on or after January 1, 2004.

(f) MEDICARE PAYMENT FOR OUTPATIENT CLINICS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, for purposes of determining the rate of reimbursement under title XVIII of the Social Security Act, any outpatient or ambulatory care clinic (whether freestanding or provider-based) operated by the Indian Health Service, by an Indian Tribe, or by a Tribal Organization (as such terms are defined for purposes of the Indian Health Care Improvement Act) shall, upon the election of such clinic, be reimbursed on the same basis as if such clinic were a hospital outpatient department of the Indian Health Service.

(2) EFFECTIVE DATE.—Paragraph (1) shall apply to payment for services furnished on or after January 1, 2004.

(g) REVIEW OF MEDICARE AND MEDICAID PAYMENT SYSTEMS.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a review of the extent to which the payment methodologies applicable under titles XVIII and XIX of the Social Security Act (including under section 1880 of such Act, as amended by this section, section 1911 of such Act, as amended by section 5(a), and including payment methodologies in effect at the time the review is undertaken and payment methodologies effected under this section or section 5) take into account the unique or special circumstances of the provision of covered services to Indians by the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act).

(B) MATTERS CONSIDERED.—In particular, the Secretary shall review the sufficiency of the payment amounts under such methodologies in assuring access to care and payment rates consistent with the payment rates for most favored providers.

(C) CONSULTATION.—In conducting the study, the Secretary shall consult with the In-

dian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

(2) REPORT.—Not later than 2 years after the date of implementation of the amendments made by subsection (a) (or, if later, the date of implementation of the amendments made by section 5(a)), the Secretary shall submit to Congress a report on the review under paragraph (1). Such report shall include recommendations for such adjustments to such payment methodologies as may be necessary to assure that payment amounts under the medicare and medicaid programs to such Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations are sufficient to provide access to quality care.

(3) RETENTION OF CURRENT PAYMENT METHODOLOGY.—Notwithstanding any other provision of law, the Secretary shall retain the all-inclusive payment methodology for encounter rates for the Indian Health Service, Indian Tribes, and Tribal Organizations under titles XVIII and XIX of the Social Security Act unless the use of such methodology is expressly prohibited or otherwise superceded by Act of Congress.

SEC. 5. AMENDMENTS TO MEDICAID PROGRAM AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

(a) EXPANSION OF MEDICAID PAYMENT FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

''INDIAN HEALTH PROGRAMS''; and

(B) by amending subsection (a) to read as follows:

''(a) The Indian Health Service and an Indian Tribe or Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) shall be eligible for reimbursement for medical assistance provided under a State plan with respect to covered items and services it furnishes if it meets all the conditions and requirements which are applicable generally to the furnishing of such items and services under this title.''.

(2) ELIMINATION OF TEMPORARY DEEMING PROVISION—Such section is amended by striking subsection (b).

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is redesignated as subsection (b) and is amended to read as follows:

''(b) The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe or Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan.''.

(4) REFERENCE CORRECTION.—Subsection (d) of such section is redesignated as subsection (c) and is amended by striking ''section 405'' and inserting ''section 401(d)''.

(b) SEEKING ADVICE FROM INDIAN HEALTH PROGRAMS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (64), by striking ''and'' at the end;

(2) in paragraph (65), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (65), the following new paragraph:

''(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian Tribes, Tribal Organizations, or Urban Indian Organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) providing health care in the State for which medical assistance is available, provide for the establishment and maintenance of the advisory process described in section 409(b) of such Act.''.

(c) SCHIP TREATMENT OF INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting ''or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)'' after ''Service''.

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The CHAIRMAN. Now I would like to turn to our chairman from the House. Chairman Pombo, do you have an opening statement?

Mr. POMBO. Yes; I do. Thank you, Mr. Chairman.

STATEMENT OF HON. RICHARD W. POMBO, U.S. REPRESENTATIVE FROM WASHINGTON, CHAIRMAN, HOUSE COMMITTEE ON RESOURCES

Mr. POMBO. I want to thank Senator Campbell for agreeing to make today's hearing a joint hearing with the House Resources Committee. Holding a joint hearing should send a signal that we can develop a bill to address the health care needs of American Indians and Alaska Natives on a bipartisan basis.

Anyone who has studied the statistical data compiled by the Census Bureau and by health care experts understands there is a profound lack of and access, to quality health care for American Indians and Alaska Natives.

Living conditions for hundreds of thousands of Native Americans lag far behind the rest of the population, whether they live in a reservation or an urban area. These conditions are unacceptable and there have to be new approaches that maximize the huge potential in Indian country to improve health care and disease prevention.

Exploring new ways to raise the quality of health services for American Indians and Alaska Natives is not an option for Congress. It is a basic obligation.

One way to address health problems for American Indians and Alaska Natives is to improve basic infrastructure needs such as safe water, sewer, waste disposal and modern medical facilities. Unless the bricks and mortar are in place, then we will be reduced only to responding to outbreaks of health problems, not preventing them. I am glad today's witnesses will especially address these issues.

I look forward to the testimony on these aspects of H.R. 2440 and S. 556. I thank the chairman for yielding.

The CHAIRMAN. Thank you, Chairman Pombo.

I'm delighted to see some of my old friends from the years I served in the House. I don't know if you have opening statements but why don't we start with Congressman Kildee. If you have a statement, go ahead.

Mr. KILDEE. Thank you very much, Mr. Chairman.

STATEMENT OF HON. DALE E. KILDEE, U.S. REPRESENTATIVE FROM MICHIGAN

Mr. KILDEE. I am happy you and Mr. Pombo are having these hearings as a member of the House Resources Committee and co-chairman of the House Native American Caucus, I think this is very important. If by chance we are called back for votes, I will leave Kim TeeHee of my staff who handles all matters of the Native American Caucus to hear all the testimony.

The reauthorization of this act will provide a more comprehensive approach to the delivery of medical care to Native people. The House bill is based upon the recommendation made by the Indian health community including tribal leaders, tribal health directors, health care experts and Native patients themselves. Its primary ob-

jective is to improve access to quality medical care for the Native American population.

I look forward to hearing testimony this morning and would ask consent that my entire statement be included in the record.

The CHAIRMAN. It will be included in the record.

[Prepared statement of Mr. Kildee appears in appendix.]

The CHAIRMAN. Why don't we go back and forth? Senator Murkowski, did you have any comments?

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. Good morning and thank you for the hearing this morning with our House members on a very important issue for us in my State.

I would like to welcome those Alaskans we will be hearing from this morning, Chief Andrew Jimmie from Minto and Steve Weaver from Anchorage. I also see some other Alaskans in the audience. This is our committee's second hearing on Indian health care reauthorization but it's the first one that has taken place after the National Steering Committee's bill was introduced in the other body.

There are many good things in this legislation but what I particularly like about it is that it is not necessarily an Alaskan bill or a Navajo bill or an urban bill, it is a national bill which was derived through the very diligent work of Native health leaders throughout Indian country. I hope, Mr. Chairman, that through the good work of the National Steering Committee, we will form the nucleus of this bill that we will markup in the Committee on Indian Affairs.

I am very pleased that we will be hearing from Steve Weaver on the second panel. Oftentimes when you think of Indian health, we think of the doctors and the nurses. Steve is an engineer, specializing in sanitation and environmental health. His expertise is in preventing disease by focusing on water quality and sanitation. It is so important that we do focus on these preventative first step measures, so I am pleased he is here today to help us as we talk about healthy families and healthy communities.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you.

Mr. Faleomavaega.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman.

STATEMENT OF HON. ENI F.H. FALEOMAVAEGA, U.S. DELEGATE, AMERICAN SAMOA

Mr. FALEOMAVAEGA. I would like to echo the sentiments expressed earlier by my colleagues to thank you for the initiative and your leadership in calling this joint hearing, along with our distinguished chairman, Mr. Pombo from California. I think this effort certainly demonstrates the urgency of this legislation that has been on the shelf now for 4 years. Our Indian communities have deliberated and have had so many consultations for many years now and I sincerely feel this joint hearing gives it a sense of urgency that we need to pass this legislation as soon as possible. We thank you for doing this.

For those of us on the House side, it's nice to be here once in a while to see how glorious and big the chambers are.

The CHAIRMAN. Actually, we're a pretty friendly crowd. You didn't have to sit that far away.

Mr. FALEOMAVAEGA. I don't know about that, Mr. Chairman. We kind of felt we were being intimidated by the gloriousness of this beautiful chamber but as a former colleague and certainly as a member of our committee, Mr. Chairman, we are delighted to be here and look forward to hearing from our witnesses this morning.

The CHAIRMAN. Congressman Cole, did you have a statement?

Mr. COLE. Just briefly, Mr. Chairman.

STATEMENT OF HON. TOM COLE, U.S. REPRESENTATIVE FROM OKLAHOMA

Mr. COLE. I'd like to echo my colleagues' appreciation for you and Chairman Pombo having this joint session. It is an extraordinarily important problem an one that's been allowed to languish far too long. I appreciate your initiative. I hope we can develop a bipartisan consensus on this legislation and move ahead. I particularly hope during the course of the hearing if we have an opportunity to look at not only the depth of the problem overall but some of the disparities in funding at the tribal level. Representing a State that has many, many Native Americans but not much in the way of reservations, we've lagged in funding compared to some of the other tribes.

Certainly we appreciate your initiative and this opportunity to look at these problems and move ahead.

The CHAIRMAN. Congressman Udall from the great State of Colorado, any comments?

Mr. UDALL. Thank you, Mr. Chairman.

STATEMENT OF HON. MARK UDALL, U.S. REPRESENTATIVE FROM COLORADO

Mr. UDALL. I too want to associate myself with the remarks of my Chairman, Mr. Pombo, Mr. Faleomavaega and the rest of the panel. I want to underline my commitment to proceeding as quickly as possible. We all know this has been long in arriving and we need to get this legislation passed and to the President's desk.

I look forward to working with everybody here to see that we do that as soon as possible.

Thank you, Mr. Chairman.

The CHAIRMAN. Congressman Grijalva?

Mr. GRIJALVA. Thank you, sir.

STATEMENT OF HON. RAÚL M. GRIJALVA, U.S. REPRESENTATIVE FROM ARIZONA

Mr. GRIJALVA. I also would join with my colleagues in extending the appreciation to you, Senator, and to our Chairman for having this hearing. I want to associate myself with the comments made by my colleagues and look forward to an expedient process and some quick movement in assuring that access and a health delivery system is available to our Native American brothers and sisters.

Thank you, sir.

The CHAIRMAN. Thank you.

Congressman Pallone, any comments?

Mr. PALLONE. Thank you, Mr. Chairman.

STATEMENT OF HON. FRANK PALLON JR., U.S. REPRESENTATIVE FROM NEW JERSEY

I just wanted to say that both of you, Senator Campbell, as well as our House Chairman Pombo, have really highlighted and shown a tremendous concern over this issue. Senator Campbell obviously for a number of years and Congressman Pombo over the last couple months, particularly last week, has shown on the House Resources side that he is willing to move forward on a number of these initiatives because he realizes how important they are.

I just wanted to say briefly I think there is a tremendous problem, I would call it a crisis, in terms of health care services in Native America primarily because you've had an explosion in the Native American population but that the IHS has not been able to keep up, primarily because of funding. I think lack of funding is a major issue.

There is also the fact that in Congress, I think we have not paid enough attention to the lack of money for facilities, for new construction and perhaps the Administration more and more, and I don't just mean this Administration but the last 10 years or so, seems to be relying on the tribes more and more to pay for their own services, particularly with regard to new facilities and renovation of facilities. I think that is wrong. I really see provision of health care services for Native Americans as an entitlement, as something we are required pursuant to the Constitution and treaties over the years to provide. I don't think we should rely more and more on their providing their own money. I think we have to increase the funding.

In addition, there are just so many changes that we haven't paid attention to over the last 10 or 20 years, the need for more preventative services, home health care, nursing homes, the changes in the demographics so that more and more Native Americans are now in urban areas and that those problems need to be addressed. Although there is a crisis, I think that we can identify what the needs are. I know that people on this committee, including the leadership, are very concerned and know what to do.

What we need to do is educate the rest of Congress and try to move the legislation and get our other colleagues motivated beyond these two committees to move these measures and realize the crisis we face, and that it is going to take a lot more money and time to address this.

I'm very pleased we are having this hearing today. I want to thank the two Chairmen in particular for their concerns.

The CHAIRMAN. Thank you.

Any comments, Congressman Carson.

Mr. CARSON. Thank you very much, Senator Campbell.

STATEMENT OF HON. BRAD CARSON, U.S. REPRESENTATIVE FROM OKLAHOMA

Mr. CARSON. I'd like to thank you and Chairman Pombo for holding this hearing too. Of course I have a great interest in this issue representing the most Native American congressional district in

the country, being a member of the Cherokee Nation myself and the son of a career of Bureau of Indian Affairs employee. I know how important this legislation is to the many Native Americans both in Oklahoma and across the country.

I am particularly proud that two Oklahomans will today be testifying before this committee, Carmelita Skeeter who runs a tremendously successful health care center in Tulsa, Oklahoma serving the Native American population, as well as Dr. Charles Grimm, the interim director of the IHS. He did a tremendous job in the State of Oklahoma and I understand his nomination and the hearings on his confirmation are proceeding nicely and we look forward to this service to this Administration as the Director of IHS.

Oklahoma has more than 300,000 patients in IHS and there is only 1.6 million nationwide. You can imagine when you have 20 percent of the IHS population, you are very concerned about what is going on within the institution.

We appreciate your holding this hearing today. I am proud to be a cosponsor of H.R. 2440, the House version of the Indian Health Care Improvement Act reauthorization, and we look forward to what the panel has to say on this very important matter.

The CHAIRMAN. Thank you.

Congresswoman Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman.

STATEMENT OF HON. DONNA M. CHRISTENSEN, U.S. DELEGATE FROM VIRGIN ISLANDS

Ms. CHRISTENSEN. I want to join my colleagues in thanking both you, Chairman Campbell, and Chairman Pombo for holding this very important meeting and also to say it is very timely as the Minority caucuses in the House are working with members of the Senate to put all of the initiatives that we have been advocating over several past Congresses into one comprehensive minority health bill. Also, to say as chair of the Health Brain Trust of the Congressional Black Caucus and as a physician, it is my hope that at the end of this process, we will reauthorize the Indian Health Care Improvement Act in such a way that we can truly begin to rectify the deficiencies of past efforts and pass a bill that will bring the health of Native Americans not just on par with what we consider average for Americans, because if we include the African American, the Hispanic American, the Asian Pacific Islanders what is considered American health will be far below what we should be aspiring to.

Rather, we want to develop a vehicle that will develop the high level of health attained by those of full and unfettered access to health services to a bill that provides equal access to culturally sensitive, comprehensive, easily and universally accessible health care provided mostly by the increasing cadre of Native American health providers that will be trained under this bill, with best practices determined by Native American and Alaska Native led and specific research provided in communities that are environmentally and socio-economically supportive of good health and developed and directed by the communities and the tribes themselves fully funded and supported with technical assistance from the Federal Government and the agencies that can provide such technical assistance.

I want to once again thank you for this hearing and I look forward to the testimony of our witnesses.

The CHAIRMAN. Thank you.

We will now start with the first panel which will be Charles Grim, director, Indian Health Service, accompanied by Gary Hartz, acting director, Office of Public Health, Indian Health Service; Richard Olson, acting director, Division of Clinical and Preventive Services; Mrs. Rae Snyder, acting director, Urban Health Office; and Steven Nesmith, assistant secretary for Congressional Affairs, Department of Housing and Urban Development.

We'll start by telling you that all of your written testimony will be included in the record. If you would like to abbreviate, that would be fine. We will start with Mr. Grim first.

STATEMENT OF CHARLES GRIM, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY GARY HARTZ, ACTING DIRECTOR, OFFICE OF PUBLIC HEALTH, INDIAN HEALTH SERVICE; RICHARD OLSON, ACTING DIRECTOR, DIVISION OF CLINICAL AND PREVENTIVE SERVICES, INDIAN HEALTH SERVICE; AND MRS. RAE SNYDER, ACTING DIRECTOR, URBAN HEALTH OFFICE, INDIAN HEALTH SERVICE

Mr. GRIM. Thank you, Chairman Campbell, Chairman Pombo, and distinguished members of both committees.

We are very excited too within the Indian Health Service for this joint hearing to be able to talk about the issues before both the House and the Senate.

You have introduced the staff I have here. They won't be making any opening statements. I will be making the opening statement for the agency but they are here should we have questions. They are technical matter experts on a number of these issues today.

We are pleased to have this opportunity to be able to testify on behalf of Secretary Thompson on both the House and Senate bills to reauthorize the Indian Health Care Improvement Act. For the record, I'm submitting my written statement and it contains specific information about the agency including the legislative and legal history regarding the United States' commitment to tribal nations and some of the national challenges that we're facing to improve the health of American Indians and Alaska Natives. My written statement also contains comments on specific aspects of the proposed legislation that I won't cover in my oral statement so that we can conserve time.

As I testified last April, there is no single piece of legislation that will affect the future health status of American Indians and Alaska Natives more than the Indian Health Care Improvement Act Reauthorization of 2003. For the past 28 years, the Indian Health Care Improvement Act has been the basis for extending the life span of Indian people by 7 years which is still 6 years below that of the rest of the Nation. It has helped us to address the basic health needs of a population that was not benefiting from the technological and medical advances of an industrialized nation and it has also assisted us in identifying current and future health challenges.

To continue to make progress in raising the health status of Indian people to at least the level of the rest of the Nation requires

us to modify the Indian Health Care Improvement Act of 1976 to reflect the health status of the Indian population of 2003 as best we can and to have it reflect the health status of Indian people as we project it into the future until the next reauthorization.

The legislation under consideration today reflects the proposed language developed over a 2-year period by Indian tribes across the Nation and adopted by both committees of Congress. Our Nation faces many priorities today, many of which overshadow but do not diminish the importance of other priorities. As requested by the committee, I am going to focus my brief remarks on the highlighted areas of health disparities, health care facilities and urban Indian health.

My written statement includes some health statistics and the agency can supply members with more information if requested. Three simple statements to remember regarding American Indian and Alaska Native health disparities are: First, Indian people continue to experience disease and illness at greater rates than the rest of the Nation; second, Indian people continue to prematurely die at rates greater than the rest of the Nation; and third, Indian people continue to experience reduced access to health services and care compared to the rest of the Nation.

It is well publicized and referenced that Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the United States general population. Many American Indians and Alaska Natives who receive a diagnosis of diabetes, high blood pressure and high cholesterol levels, cardiovascular disease, alcoholism and obesity consider it a fatal diagnosis.

The proposed language of the Indian Health Care Improvement Act can help the Indian health system of the Indian Health Service, tribal health programs and urban Indian health to develop and implement health promotion and disease prevention strategies so that healthy behavior choices and lifestyles will begin to significantly reduce the health disparity rates. It also yields an even more important humanitarian benefit of reducing pain and suffering and prolonging life.

We were successful in working with Indian nations through the Indian Health Service with infectious diseases and conquering those and I think we can do it again for chronic diseases with the help of Congress.

The IHS Health Care Facilities Program, including the tribal program specifically, are responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services with over 9 million square feet of space. In the proposed bill, section 302(B)(3)(c) specifically proposes that IHS Sanitation Facilities Construction funds will not be used to support service of sanitation facilities to the Department of Housing and Urban Development homes. The bill is not clear that homes constructed through HUD should also include the necessary infrastructure to make a home complete including safe water and sewer and wastewater disposal systems for the home. The IHS and HUD have cooperated over many decades on the construction of homes and reservation communities with IHS providing the expertise and

development of supporting the sanitation and sewage systems that the HUD homes would then hook into.

Without clarity in the language, there may come a time when interpretation may result in IHS funds being expended on sanitation systems of HUD homes which would in turn redirect IHS funds from providing services to existing homes without water, sewer and solid waste facilities. Newly constructed HUD homes should be funded to cover everything including the home itself and to the street hookup. We request that you consider clarifying this point in the proposed bill.

Title V of the Indian Health Care Improvement Act provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to the Indian Health Service. The IHS currently contributes funds toward the operating expenses of 34 independent urban Indian health programs including programs in Oklahoma City and Tulsa that are demonstration programs. These programs provide a range of services. In 1978, the entire State of Oklahoma was designated as a contract health service delivery area which means that the Indian beneficiaries could reside anywhere in the State and maintain their eligibility for both direct services and contract health services.

The 1992 Congress amended the Health Care Improvement Act to establish two demonstration projects with Tulsa and Oklahoma City clinics to be treated as service units in the allocation of resources and the coordination of care. This new and innovative approach to ensuring health services were accessible to all eligible populations in Oklahoma has resulted in a hybrid system. Each program maintains its status under the title V as an urban Indian organization, yet the programs function like other IHS service units and report on the resources and patient management system of the Indian Health Service with data utilized for inclusion in the allocation of resources.

Most service populations and overall utilization of services have dramatically increased since these programs became demonstration projects and from the fiscal year 1994 specific congressional line item funding increases. They have been able to use the best of both urban and IHS structures to build a community controlled, high quality health system in a State designated as a contract health service delivery area.

On the other hand, the hybrid system has raised a few concerns with some of the Oklahoma tribes that operate their own health programs under the Indian Self Determination and Education Assistance Act, Public Law 93–638 as amended. The issue in its most basic terms is that the two urban programs have some aspects of a service unit but their funding is not subject to transfer to the tribes under Public Law 93–638 contracts or compacts as our non-hybrid service units are.

With an environment of reduced resources and an increasing population with greater health needs, it's expected that the issue of tribe shares of urban Indian programs, especially the hybrid programs, will receive more attention than they have in the past.

As review of this far-reaching, complex legislation continues, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the In-

dian Health Care Improvement Act and will be happy to work with the committees, the National Tribal Steering Committee and other representatives of the American Indian and Alaska Native communities to develop a bill that is fully acceptable to all stakeholders in this important program.

Mr. Chairman, that concludes my statement. I want to thank you for the opportunity to discuss reauthorization of the Indian Health Care Improvement Act. We will be happy to answer any questions you may have.

[Prepared statement of Dr. Grim appears in appendix.]

The CHAIRMAN. Thank you, Dr. Grim.

I understand Admiral Hartz, Dr. Olson, and Ms. Snyder are resource people but do not have statements, is that correct?

Mr. GRIM. That is correct.

The CHAIRMAN. Now we will go to Steven Nesmith.

I might tell my colleagues that Mr. Nesmith is really assistant secretary for Congressional Affairs. I understand your background is not in Indian health. Is that correct?

Mr. NESMITH. That is correct, sir.

The CHAIRMAN. Hopefully we won't put you on the spot too much. Go ahead.

STATEMENT OF STEVEN NESMITH, ASSISTANT SECRETARY FOR CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. NESMITH. As this is a joint hearing, Chairman Campbell and Chairman Pombo, Vice Chairman Inouye, and members of both committees, thank you for inviting me here to provide comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003.

My name is Steven Nesmith and I am the assistant secretary for Congressional and Intergovernmental Affairs at HUD.

As you know, the Public and Indian Housing, PIH, is responsible for the management and operation and oversight of HUD's Native American programs. These programs are available to 560 federally-recognized and a limited number of State-recognized Indian tribes. We serve these tribes directly or through tribally designated housing entities by providing grants and loan guarantees designated to support affordable housing community and economic development activities. Our tribal partners are diverse. They are located on Indian reservations, in Alaska Native villages and other traditional Indian areas.

In addition to those duties, PIH's jurisdiction encompasses the Public Housing Program which aides the Nation's 3,000 plus public housing agencies in providing housing and housing related assistance to low income families. It is a pleasure to appear here before you and I would like to take the opportunity to express my appreciation for all of your continuing efforts to improve the housing conditions of American Indians and Alaska Native peoples.

Much progress has been made and tribes are taking advantage of new opportunities to improve the housing conditions of the Native American families residing on Indian reservations, on trusts or restricted Indian lands and in Alaska Native villages. This momen-

tum needs to be sustained as we continue to work together toward creating a better living environment throughout Indian country.

At the outset, let me reaffirm the Department of Housing and Urban Development's support for the principle of government to government relations with Indian tribes. HUD is committed to honoring this fundamental precept in our work with American Indians and Alaskan Natives. On behalf of Secretary Martinez, thank you for the opportunity to provide this testimony on S. 556.

The Department agrees that the Indian Health Service, a division of the Department of Health and Human Services, is vital to the well being of individual Indian families and the Native American community as a whole. Native Americans often have no other means to receive the health care assistance and related activities provided by IHS.

HUD's Office of Native American Programs continues its ongoing dialogue with IHS representatives to coordinate our activities in a manner that supports tribal sovereignty, self determination and self governance. The Department also participates in a Federal Interagency Task Force on Infrastructure with the IHS, the Environmental Protection Agency, the Bureau of Indian Affairs and the Department of Agriculture. It is within this perspective that the following comments are offered on behalf of HUD and this bill.

As you are aware, in 1996, the Native American Housing Assistance and Self Determination Act became law. NAHASDA changed the way in which housing and housing related assistance is provided to Native American families. Prior to the Act, Indian housing authorities and Indian tribes applied for a variety of competitive and categorical grant programs usually with differing program eligibility and reporting requirements.

NAHASDA created the Indian Housing Block Grant Program which is a non-competitive formula grant made to Indian tribes or tribally designated housing entities. Under the Indian Housing Block Grant Program, an Indian tribe or the tribal designated housing entity submits to HUD a 5-year and a one year housing plan. The housing plan contains information about how the recipient will use its block grant funds to engage in the six affordable housing activities authorized by NAHASDA.

Once the Indian housing plan is found to be in compliance with the statutory and regulatory requirements, the tribe or that designated entity executes a grant agreement to receive the Indian housing block grant allocation. The Indian housing block grant formula is based on housing needs of each of the tribes and the tribes designated entity ongoing operation, maintenance needs and for the dwelling units previously developed under the Indian Housing Program authorized by the U.S. Housing Act.

The Indian housing block grant formula is calculated by dividing the total amount appropriated for each fiscal year among the number of eligible grant recipients. Formula components and variables are weighted to ensure that the complexities and differences among tribes are taken into consideration. Each tribe's formula allocation reflects these factors.

The NAHASDA regulations as described in the Code of Federal Regulations requires that the Indian housing block grant formula be reviewed by the calendar year 2003 for possible modification or

revision. At present, HUD is engaged in negotiating rulemaking commonly referred to as NEGREG with a 26-member committee comprised of a broad cross section of tribal stakeholders. The first NEGREG session was held in April of this year and additional monthly meetings are ongoing and are scheduled through September.

Let me turn to the specific comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003. As you know the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. The Administration has not taken a position regarding the transfer of NAHASDA funds between HUD and HHS. We do, however, have concerns about transferring NAHASDA funds between Federal agencies when NAHASDA now provides for the direct distribution of Indian housing block grant funds to tribes and their housing designated entities based on a formula negotiated between the tribes and HUD.

An affordable housing activity under the Indian Housing Block Grant Program is development which includes infrastructure such as site improvements and the development of utilities and utility services for housing. The provision of water and sanitation facilities are included within this category. Tribes and tribal designated housing entities may currently enter into agreements with IHS to provide these services or they may choose another service provider.

We believe that this is in keeping with the policy of self determination that is articulated in NAHASDA. Since 1997, nearly $228 million has been transferred to IHS through the tribal designated housing entities for offsite sanitation facilities. Tribes and their designated entities continue to make difficult budgetary and management decisions on how to prioritize their Indian housing block grant dollars which is consistent again with tribal self determination and self government.

Let me assure the committee that we will work with both committees and with our Federal partners in HHS and other Federal agencies, the tribes and their designees to ensure that the housing infrastructure needs in the Native American communities are met in the most efficient manner possible.

We are nevertheless concerned about any provision that might erode the self determination which we believe is critical in NAHASDA.

Thank you for the opportunity to express the Department's views.

[Prepared statement of Mr. Nesmith appears in appendix.]

The CHAIRMAN. Thank you.

Since our colleagues in the House are going to have further to walk because there is a vote than we have to in the Senate, I am going to yield to them for questions first. We will start with Chairman Pombo.

Mr. POMBO. Thank you very much. I appreciate the opportunity.

The House Interior Appropriations bill specifically included committee language which states that IHS sanitation funds should not be used to provide sanitation facilities for new homes funded by the housing programs of the Department of Housing and Urban Development. I know, Dr. Grim, that in your opening statement you

talked about this issue. Could you expand upon that for me as to what your level of support or opposition to that particular language is?

Mr. GRIM. Yes, Mr. Chairman; the way that came about was our appropriations committees have over the years included that language because HUD funded home projects prior to NAHASDA had infrastructure funds included for sanitation facilities for newly funded HUD homes. Once NAHASDA was put in place, it was the tribes choice of what to use those funds for, whether to build housing infrastructure and so forth.

The IHS program separates and, apart from that, looks at existing homes without adequate sanitation facilities or newly built homes built with other than HUD funds. We currently have a backlog of those homes as well, so the two programs are separate. So our committees have wanted to ensure that moneys coming through the Indian Health Service were used for existing homes with that need or with newly built homes other than HUD homes.

Mr. POMBO. So you generally in support of that because you want to keep those two programs separate?

Mr. GRIM. As mentioned by Mr. Nesmith, we've worked jointly with HUD over the years to try to ensure that the two programs work together but they are two separate programs.

Mr. POMBO. Can you tell me a bit more about what you are currently doing to deal with that backlog? I've been told that the backlog is substantial at this point. Can you expand upon that a bit for me?

Mr. GRIM. The current backlog we have estimated in feasible projects, those able to be completed roughly is around $900 million right now. We keep records on that and those records do not sometimes include newly built HUD homes that may or may not have adequate facilities. Once they become existing homes, we try to get those added to our inventory.

One of the things we try to do on an annual basis, we have currently a $94-million appropriation to deal with new and existing homes and we have a priority system where we try to prioritize those in most need. We are trying on an annual basis to work on those backlogs.

Mr. POMBO. You said something I have a real question on and that is when a newly constructed HUD home becomes an existing home, then you can use funding to provide the sanitation services. Why would you allow a home to be built without the sanitation services?

Mr. GRIM. I may let Admiral Hartz take a crack at this after I finish but regarding existing HUD homes, the Indian Health Service staff work in concert with HUD on those homes. However since the passage of NAHASDA the block grants have now been transferred to tribes. There is extreme pressures out there due to the backlog and need for housing in Indian country and there are more and more pressures on tribes to get existing homes in place.

The IHS does not have direct control over any of the NAHASDA housing projects themselves. We come in as technical assistants but we do have funds, the $94 million I referenced, to help existing homes or those that have been built with funds other than HUD such as State programs or tribal funds and things like that to try

to get adequate water and sanitation facilities to them. Many times, in Indian country it's not like it is in an urban setting like Washington, DC or Maryland where all you have to do is hook up to a water main that is a few feet from the house. Sometimes there are many, many miles to traverse to get to a water or sewer system. So it is not as easy as it sounds sometimes when a home goes up many, many miles from a location where there is adequate hookups to sanitation and water. Sometimes that occurs.

The point I would make is the IHS works in tandem with HUD and with tribes trying to ensure that safe water and sanitation facilities go in but the IHS itself is not the one responsible for the building programs. We just assist with sanitation and those facilities.

Mr. HARTZ. Mr. Chairman, I can build on that with a couple of points.

I think historically as pointed out, we have had an excellent relationship with HUD in making sure that the door knob is talking to the toilet seat as we get these new homes built. I think that's been shown going back to when Congress actually started putting that language in our appropriations bill which dates back to the early 1980's. It had to do with some arrangements that were worked out at that time with OMB and Secretary Pierce I believe in 1981.

The money started flowing to ensure that the HUD units were provided sanitation facilities either through an arrangement with HUD directly or through the Indian Housing Authorities and/or the Indian tribes depending on how they were set up locally. Those resources contributed from the HUD Indian Housing Program at that time grew from $5–$6 million to $25 million. That contribution to the Sanitation Facilities Program of IHS was of tribes' choosing. They could do the construction themselves, they could provide it to IHS. Many times the reason they would provide it to IHS is because you can then do a total community concept in development of infrastructure as opposed to doing a piecemeal approach where houses get dropped in a location and you only have dollars to do just that little piece for infrastructure. Infectious diseases don't follow those kinds of boundaries when the same children from different places show up in the school system.

It grew in 1994 to almost $25 million, the contribution that was coming out of the Indian Housing Program from HUD most of the time, 90 plus percent of the time, the money actually was a decision made by the tribes exercising self determination before that was even passed through the HUD authorizations to provide those dollars to IHS to carry it out.

There were lots of arrangements by which that was done. Sometimes the tribes would pool the dollars and the tribes actually did the construction as on the Navajo Reservation to this day, they do 99 percent of all construction related to infrastructure on water, sewer, solid waste, et cetera.

It was only after the passage of NAHASDA that the numbers dramatically dropped. We were down as low as $1.3 million. Last year in 2002, it was about $4.4 million that was provided. That is totally a tribe decision. We concur with that.

Getting back to your original question about why that language was put in our appropriation, we are so limited in our resources to address the sanitation deficiency system that Congress asked us to identify in that universe of need being at $1.5–$1.6 billion for all of the existing homes, plus address anything new coming on, we weren't in a position, at least the appropriators thought, to pick up additional responsibility for HUD sponsored units because we have $94 million we are addressing against the feasible amount of $900 million and of that $94 million, we put about half of it to address new units every year. In 2002, we had a few hundred units we weren't even able to address, about 350 units, where individuals were financing and paying for their homes themselves that we couldn't get to within the priority systems that exist.

That's a little more background. I hope I haven't expounded to far in some of the detail but I'm prepared to expound further as needed.

Mr. POMBO. Thank you, Mr. Chairman.

The CHAIRMAN. I can look at the clock and see that by the time we get done with the next panel, we are going to run out of time. I would ask my colleagues to keep their questions down to 3 or 4 minutes.

Congressman Kildee.

Mr. KILDEE. On the question of sanitation, the Senate bill apparently prohibits the use of IHS funds for sanitation in HUD housing whereas the House bill does not contain that prohibition. How does the IHS suggest we clarify the language referring to IHS funding for sanitation in HUD constructed houses?

Mr. GRIM. As I pointed out earlier, right now the two programs are really separate programs. We are serving that backlog of existing homes that do not have adequate safe water and sanitation facilities as well as newly built homes that are built with other than HUD funds. There are a large number of those being built annually.

There are currently two separate programs. The two bills that have been introduced with differing language, I suspect in conference committee will be dealt with but if our funds were to be merged with HUD funds, it appears it would be taking two separate programs and merging them into one. We would have a difficult time then perhaps addressing the existing home backlog.

Mr. KILDEE. Perhaps the House and Senate can get together and try to bring our language to more compatibility to see what we can do to encourage the IHS. In some very remote parts of Michigan where I come from where there are no water lines as such and no sewer lines, they do have septic facilities and there is groundwater they can use for the operation. I think remoteness alone, there might be some areas where you don't have the groundwater, would not always preclude the possibility. This certainly relates to health, there is no question about that.

The Saginaw Chippewa Tribe, in my State but not my district, in 1934 the Federal Government built a number of half houses for the Indians. Some of those half houses are still there, maybe have been finished off and changed a bit but I guess the Indians were grateful to get the half houses but they really were half. I think

we certainly should have come a long way since 1934 and a long way since 1980.

I'm willing to work with you to see what we can do to help the IHS and HUD work more closely together to provide this. I also believe we should elevate your position to that of assistant secretary.

Mr. GRIM. Thank you, Congressman Kildee. I might point out for everyone's information that the language in the Senate bill relative to the way we work with sanitation facilities is the current practice that is being carried on.

The CHAIRMAN. Congressman Cole, any questions?

Mr. COLE. No; Mr. Chairman.

The CHAIRMAN. Congressman Faleomavaega.

Mr. FALEOMAVAEGA. Again, I want to thank Dr. Grim for his testimony.

Mr. Grim, I think one of the problems that left this proposed legislation for authorization hanging was the question of scoring. I notice that some estimates come out to $2 billion, $3 billion, $6.9 billion for the 10-year period. It seems we are squeezing blood out of a turnip. Why is it we are having such a difficult in time in trying to arrived the best cost estimate when it is so simple to get $70 billion to clean up Saddam Hussein's mess, so instantly it seems. We're asking for a mere $3 billion.

From the statement here, I am concerned that alcoholism, is 770 percent higher than the U.S. population; diabetics, 420 percent higher; accidents, 280 percent higher; suicide, 190 percent higher; homicide, 200 percent higher and we can't even find a common ground to get the proper money.

The bottomline, Dr. Grim, is funding. What is the Administration's best estimate of the level of authorization needed for the 10-year period, because I'm getting all kinds of figures. I'm a little confused. Can you give us your best estimate of how much authorization is needed to properly fund our Indian Health Care Program?

Mr. GRIM. The current bill, both House and Senate, I don't currently have available today to be able to tell you. Because of the variabilities in the two bills, there are some significant variabilities in title IV for example.

Mr. FALEOMAVAEGA. We can clear that up on our side. I'm asking the Administration's position. What is your position on this? How much should be authorized for of this legislation?

Mr. GRIM. We have a study that's been done internally that only looks at the personal health care expenditure needs and doesn't look at our public health infrastructure which is also a big need. We also have a tribal needs based budget the tribes have presented.

Mr. FALEOMAVAEGA. Dr. Grim, you still aren't understanding my question. The bottomline, what is the Administration's recommendation regarding the level of authorization needed to assist our Indian community for the next 10-year period? If you can't answer it right now, can you submit that for the record?

Mr. GRIM. Yes, sir; I will submit that for the record. Because of the variability in the bills, I can't answer that.

Mr. FALEOMAVAEGA. I really would appreciate that.

The second question, I believe the total population of Alaskans and American Native Indians is over 14 million. Am I correct?

Mr. GRIM. The American Indian and Alaska Natives we serve in our facilities is about 1.6 million. The most recent census places the number of American Indians and Alaska Natives in combination with another race at over 4 million.

Mr. FALEOMAVAEGA. $4 million. I thought it was more than that. If you could give us exactly what the Administration proposes. I made the estimate that we have about 14 million American Indians and Native Alaskans in this country. You are saying the entire health care system provides services for about one point six million American Indians and Alaska Native?

Mr. GRIM. Yes, sir.

Mr. FALEOMAVAEGA. For the rest of our Native American community, they are out there on their own, really flat out, just in the worse situation than any other ethnic group here in our country. Would you agree with me on that?

Mr. GRIM. I would say a portion of that population we are not serving has private insurance and is seeking care but that's a very small percentage. It is hard for us to place a handle on it since they don't access our health care system. The remainder of that group that is not that small percentage with private insurance or the ones seeking care from us, many of them are without health care.

Mr. FALEOMAVAEGA. One quick question to Mr. Nesmith. I know HUD is not part of the Indian health care authorization legislation. For the last fiscal year, how much monetary assistance did HUD provide Native Americans for housing?

Mr. NESMITH. The last fiscal year?

Mr. FALEOMAVAEGA. Yes.

Mr. NESMITH. About $650 million.

Mr. FALEOMAVAEGA. How much are you proposing for the coming fiscal year? I hope it is an increase.

Mr. NESMITH. I'm not sure if it's level but I can get back to you.

Mr. FALEOMAVAEGA. The $650 million in the last fiscal year provides for how many of our Native American community people?

Mr. NESMITH. We believe that would provide for the numbers you just mentioned.

Mr. FALEOMAVAEGA. My point is we are totally underserved, even with the amount of funding that HUD is providing, it is not even the tip of the iceberg as far as the community housing needs of our Native American community throughout the country. Would you agree with me on that?

Mr. NESMITH. Not being able to compare, you said it was $14 million. I would say there needs to be some improvement.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Murkowski, did you have any questions?

Senator MURKOWSKI. No; thank you.

The CHAIRMAN. Congresswoman Napolitano.

Ms. NAPOLITANO. I'd like to followup on my colleagues' questions and the health disparities issues. I'm wondering how much of the funding is going into addressing the education or training of Native Americans to be able to deal with the issues. It is not the first year that I've heard of the high percentages of these individual groups.

How are we dealing with the alcoholism, the diabetes, suicide and homicide? Accidents, that is another issue but all the others are lumped into an area that has been very prevalent in the American Indian community for many decades. It isn't the first time. What are you doing? How much money is being put into programs that will help these communities be able to deal with those issues?

Mr. GRIM. I will need to submit part of the answer to that question for the record in writing. What I can say is that our current budget is approaching $3 billion.

Ms. NAPOLITANO. Total budget of what?

Mr. GRIM. Of the Indian Health Service. You initially asked about education and we do have a scholarship and loan repayment program that we do work with trying to get American Indian and Alaska Native Youth into the health professions so they are back into their own communities. We also have a large portion of that budget that is in the health care delivery area. Approximately 50 percent of our budget in rough terms is now being administered by tribes themselves through Public Law 93–638. They are making their own decisions about the delivery of health care in their communities.

The other locations where the Indian Health Service operates the programs directly, we work closely with community health boards and tribal health boards and programs in the communities to determine priorities they want within the communities.

Ms. NAPOLITANO. What has been the result of these health delivery organizations? According to what I see here, the alcoholism is astounding. Do you have programs to actually help deal with the alcoholism problem?

Mr. GRIM. Yes; the majority of the programs that are alcohol and substance abuse programs in Indian country are run and managed by the tribes themselves. As a rough estimate, I'd say in excess probably of 95 percent of the programs and the money the Indian Health Service receives, about $130 million is what we receive in our line item for alcohol and substance abuse, well over 95 percent of that is going directly to the tribes themselves to run their programs.

Ms. NAPOLITANO. Is there an issue that what is happening is not actually being effective in taking another look at how else to approach it, working with the tribes you have authorized the money for?

Mr. GRIM. I think a large part of it is the complex nature of alcoholism. We have programs directed at both prevention and treatment, although we don't have enough inpatient treatment facilities or long term treatment facilities in many of the communities that need it. However, it is a complex mix of socio-economic factors, isolation issues, lack of adequate jobs, housing and things like that that all feed into the mix. Many of the diseases we are facing in Indian country today are behavioral and chronic as opposed to the infectious diseases we saw early on. So it requires a different mix of factors and programs that are more than just health programs alone to try to address them.

Ms. NAPOLITANO. Are those being implemented? That is what I'm trying to get at, thinking out of the box, doing new, effective methods that are going to break that cycle, that are going to assist fami-

lies in being able to be supportive of each other, the tribes to be able to get to those in alcoholism. My husband died of alcoholism so I understand it very well.

Thank you.

Mr. GRIM. Yes; I think the programs are ongoing out there, I think they are effective, I think the tribes are working within the communities to implement a more whole body wellness approach, physical, mental. emotional and spiritual. Many of them are involving their traditional ways into the programs and I think we are seeing progress. The issue is just the overwhelming numbers that we face right now.

Ms. NAPOLITANO. I'd like to hear more. If you have anything you can submit to the committee on what is actually being done, I think it is a great problem and is very hurtful to Native Americans. I think we need to be able to understand it, to be able to look at how we as a society can assist in being able to address it and help them be able to understand how hurtful it is to them and their communities.

Mr. GRIM. We will submit some information to you for the record on our programs and the things going on with the tribes. You are right, there is a huge disparity and a huge need in that arena.

Ms. NAPOLITANO. Thank you, Mr. Chairman.

The CHAIRMAN. Congressman Grijalva, any questions?

Mr. GRIJALVA. Yes; thank you, Mr. Chairman.

In the tribal working group that worked with the Indian Health Service throughout this process and as a result, much of what we're deliberating is a product of that work, did this working group take a position on the point we spend a lot of time talking about as to who is going to have the responsibility, HUD or Indian Health Service for sanitation and sewer?

Mr. GRIM. The group did take a long look at that. There are two versions as you see before you right now, one in the Senate and one in the House. I don't think there is a consensus in Indian country right now relative to how that issue should be handled, whether the money should be lumped into one sum or whether these two existing programs which have separate goals should be kept separate. I just don't think there is consensus out there in Indian country yet either.

Mr. GRIJALVA. Along the same lines, in reference to the steering committee you worked with, long and hard, as you see both bills, the Senate and the House, are there any serious omissions in this legislation, issues that those of us here should be aware of?

Mr. GRIM. I've submitted in my written testimony a number of things, some of the things this committee asked us to focus on today. Then there are a couple of overarching issues also in my written testimony. In the interest of time, I can submit some further issues in writing because it is a complex piece of legislation.

Mr. GRIJALVA. I would appreciate that, sir.

Thank you.

The CHAIRMAN. Congressman Pallone.

Mr. PALLONE. Dr. Grim, I like you personally so I don't want you to take offense from anything I say but I just don't get the sense of crisis from your testimony. When you go out to Indian country, you hear stories about people dying because of lack of access to

health care, you hear about the disparities with diabetes and alcoholism and so many other issues, and the inability to attend to those problems, and particularly with the facilities. Every time you go to a tribe, they talk about how they are on a 10- or 15-year waiting list to get a new facility or to renovate their facilities. Then you get all this stuff about funding. As Mr. Faleomavaega said, we just hear the funding is so inadequate and even more so that the notion the Federal Government is relying on the tribes to provide funding, particularly if they have a little money because they have a casino or whatever.

I'm trying to look at the larger picture and I guess I could ask two questions and if you can answer them, fine. If not, get back to me. Do you see a real crisis because I do and where is that crisis? Is it in the lack of money for facilities, is it in the diabetes area, is it an inability to provide funding for nursing home services? I hear about all these things.

The second question is, the tribes really feel, a lot of them say to me that the Government is not following through on its commitment to provide the funding federally and that they are now expected to use their own resources to build new diabetes clinics or new hospitals and almost built into the IHS the notion that the tribes are going to pay for a significant part of their health care. That's not the way it's supposed to be. Do you see a crisis? Where is it? Do you assume that they are going to pay a significant portion of their own services or construction?

Mr. GRIM. First, let me say that yes, I see a crisis. The percentage of mortality rates that our population exceeds relative to the U.S. population is not acceptable to me as the director of the Indian Health Service or as an American Indian.

Is there a funding issue? I think we are starting to see potentially higher rates of inflation in health care than we have in past years. That impacts our budget significantly. Whenever health care inflation exceeds the amount of money we receive, we have loss in buying power. We have stayed relatively static in buying power over the last decade. We have not seen a large increase in buying power in the Indian Health Service budget, not withstanding the increases Congress has appropriated to us.

I think the issue is a very complex one as I said earlier. We certainly need greater access to health care in Indian country. There are certain services that need higher levels of access than currently available but the other issue is the complex nature of health. It is not just being able to access a clinic, it is adequate and safe housing, it is economic opportunities on the reservations.

Mr. PALLONE. What about the backlog in facilities?

Mr. GRIM. We have a large estimated backlog in facilities needs in Indian country. Right now, the average age of an Indian health care facility is about 36 years of age. In the private sector, the current age of a facility is about 9 years. About 20 percent of our facilities meet that 9 years or younger average, so we have a large backlog in facility needs in Indian country.

Regarding the issue of appropriating funds for facilities, Congress has been consistent over the years in trying to keep a number of Indian health facilities projects ongoing but there is a large backlog of need out there.

Mr. PALLONE. Do you assume that a lot of these tribes are going to take care of their own needs? That is what they tell me. They say, we have to build our own clinic, we have to build our own hospital, we have to pay for this ourselves. Is there an assumption on the part of the Federal Government that is going to happen?

Mr. GRIM. No, sir; Congressman Pallone, I do not assume that and I don't think the Administration assumes that. One of the things we have seen over time is sometimes when tribes take over their own health programs and sometimes when the Federal Government still runs them, tribes have donated tribal funds or placed tribal funds into programs because of the need in particular sectors for their communities.

I do hear the same things you hear when I'm out there visiting Indian country, that they feel we should be doing more.

Mr. PALLONE. Thank you.

The CHAIRMAN. Congresswoman Christensen, did you have questions?

Ms. CHRISTENSEN. Yes; I'll try to make them short.

I've been fortunate to have Native American interns and one of them is with me, Caryle Begay, and another. I want to ask a question that comes from some of the discussions we have had.

Considering there has been a significant increase of Native Americans, Alaska Natives into urban areas, away from rural reservation areas where the majority of Indian health services are provided, what measures are being taken to focus on providing health services for this growing urban Indian population.

Natalia Arosco, an Indian on the San Pasqual Reservation, lives in a very small urban tribal reservation. They also have some unique needs for research data collection, publications and guidance for health care providers. What in this reauthorization addresses that?

Mr. GRIM. You are right in that we have seen a large demographic shift of American Indians and Alaska Natives now in urban areas. We still have 34 urban Indian programs that we provide grant funding for to operate in some existing locations. Those funds were put together through title V when Congress adopted title V of the current Indian Health Care Improvement Act. Those funds were intended to stimulate some health care services. Some are just referral and outreach and some provide more comprehensive care for areas where there were large urban Indian populations.

Under the former director, Michael Trujillo, when the Indian Health Service started consulting with Indian Health Service, tribal and urban programs more, we brought the urban partners to the table. They now take part in our work groups and policy decisions within the agency and we are trying to work more closely with them for their needs.

Ms. CHRISTENSEN. You also say under the negotiated rulemaking part of the bill that the tribal consultation may not be the most effective way to obtain necessary Indian provider input. As a physician and member of the Small Business Committee and my colleague, Grace Napolitano can attest to this, we spend a fair amount of time with CMS and their rulemaking as it relates to providers of all backgrounds.

What would be a more effective way because through the Office of Advocacy and through the Regulatory Flexibility Act we have been able to improve on their consultation. I think the Native American and Alaska Native providers deserve the same treatment.

Mr. GRIM. Specifically to the tribal consultation process, the Indian Health Service believes very strongly in that and works with tribes to that end. One of the comments made in my written testimony was that due to the number of regulations that come out of CMS, there was concern on behalf of the Administration that tribal consultation on all of the regulations coming through CMS might place an undue burden on the agency, on CMS.

Ms. CHRISTENSEN. Maybe they ought to simplify their regulation and rulemaking.

Mr. GRIM. I'll take back that information.

The CHAIRMAN. Congressman Udall

Mr. UDALL. First, I want to ask about the reauthorization and the bill that is before us. In doing that, I compliment Chairman Campbell. He has introduced a piece of legislation, S. 212, in the 107th Congress; we now have before us in the 108th Congress, S. 556. There has been a great deal of consensus building done on this bill. Is the Administration at the point of supporting the bill before this committee now, weighing in and trying to make sure it gets passed?

Mr. GRIM. The Indian Health Care Improvement Act Reauthorization bill, S. 212?

Mr. UDALL. S. 556 which Chairman Campbell has worked on very hard. It is a bill that has been around a long time and I don't believe you have a reauthorization. You're just going year by year, aren't you?

Mr. GRIM. Currently, that is correct. The reauthorization I don't believe has been extended currently but it had been extended in previous Congresses and we are still operating. I was very excited to see a joint hearing today between the House and the Senate on the various versions of the bill.

Again, both bills are complex, very long bills and the Administration has made some comments relative to their issues or concerns on specific parts of the legislation and we are still doing side by side comparisons right now, so we don't have a full analysis.

Mr. UDALL. How soon do you think you will have that?

Mr. GRIM. I would have to submit that for the record, sir, about the length of time. I'd have to check with our assistant secretary for Legislation.

Mr. UDALL. Do you think you are going to be in a position in the next couple months to be able to support this bill?

Mr. GRIM. We work very closely with both committees so that we can try to do that.

Mr. UDALL. I think that is very important because I think the approach Chairman Campbell and Don Young have taken in introducing this legislation is looking at the long term and looking at 10 years. It seems to me the more you're required to go year by year, you aren't looking at those big issues that many members of the panel have been raising. Would you agree with that?

Mr. GRIM. I think we have continued to operate our program with a long term focus, notwithstanding the fact this current bill has been pending reauthorization for a number of years, but we are very, very anxious in the Indian Health Service and in the Department of Health and Human Services to see the bill reauthorized.

Mr. UDALL. I'm happy that is the case. I want to ask one other question on this whole diabetes epidemic. I have a congressional district that is 22 percent Native American in the State of New Mexico, 9 percent Native American. I had a very poignant story told to me by a renal specialist in Santa Fe about diabetes in our community surrounding Santa Fe which we have a number of Pueblos.

He told me that 20 to 25 years ago, a gentleman that started a practice quite a while ago, they did not see very many cases of diabetes in Native American individuals that came into the Indian Health Service hospital or that were being seen privately. In his lifetime, he said this has dramatically changed. We truly have an epidemic.

I'm not a doctor. It is what he described to me but he says a lot of what is going on here has to do with diet, obesity, sedentary lifestyle, lack of exercise and it seems if this is the key, education and prevention are the way to go. What are you proposing as to how to tackle this epidemic and how to move us out of this horrible cycle we are going into?

Mr. GRIM. I think you have seen the President and the Secretary have an increased emphasis on health promotion and disease prevention in the last couple of years. Since I've been in the Indian Health Service, I've initiated a health promotion disease prevention initiative within this past year involving tribal leadership and health expertise from our facilities and clinics to try to reemphasize or bring to the forefront again health promotion and disease prevention efforts.

I think the Indian Health Service has always been strong over the years in our health promotion efforts. We run a public health program in the communities as you have heard today and some of the testimony is not only the delivery of health care but environmental health and sanitation facility issues as well.

We are trying to focus on those chronic disease issues because they are not as easily solved as some of the diseases we faced in the past. As a Nation, we are now starting to address it.

Internally, Congress has been good to devote $100 million over the last 6 years and an additional $50 million to the huge problem of diabetes in Indian country. I cannot report to you specific numbers but if you'd like them for the record, we have a large number of primary prevention programs going on in Indian communities right now. We have a large number of secondary and some minor tertiary sorts of initiatives going on with that $100 million Congress appropriated. We are seeing successes out there. We are looking at five to six overall clinical indicators and seeing movement in the right direction. We think we are staring to make impacts on the diet issues, the obesity issues, and such things that not only lead to diabetes but a lot of other chronic diseases like cardiovascular disease. Right now, cardiovascular disease is on the rise in Indian populations, 25 percent greater than the Nation as a

whole. A number of years back, we were lower than the rest of the Nation. The rest of the Nation is seeing reductions in those, we are seeing some increase. So we are working very hard on the control of blood pressure and things like that in our population.

I think there is a lot going on out there on issues like this, it is going to take years before we see significant improvements in the indicators to show success is coming.

Mr. UDALL. With the Chairman's permission, could you submit those for the record, what you are doing, what you anticipate you need in terms of money to tackle the diabetes epidemic in terms of prevention and education.

As a final followup, wouldn't you agree that it is far better to tackle these at the front end with prevention and education than dealing at the tail end where you have end stage renal disease and dialysis and the enormously expensive options that patients have at that point?

Mr. GRIM. I believe that 100 percent because I think that not only will it reduce the cost of health care in the long run and allow us to do more but I also believe it is better for our people, they will lead longer, healthier lives.

Mr. UDALL. Thank you. Let me compliment Chairman Pombo and Chairman Campbell for convening this joint hearing. I hope it will move this legislation along and we can get a 10-year authorization for the Indian Health Service.

The CHAIRMAN. If it moves along as fast as this hearing, it may be 10 years before we finish the hearing.

I'm going to submit my questions in writing. We have a series of votes starting at 12:10 p.m. in the Senate and the House will be voting right after that. We still have six people and I'm dividing the time to make sure they have equal time at the microphone.

We will thank this panel and move to the second panel which will be: Rachel Joseph, cochair, National Steering Committee on the Reauthorization of Indian Health Care Improvement Act from Lone Pine, CA and Dr. Ben Muneta, president, Association of American Indian Physicians from Oklahoma City and Steve Weaver, director, Division of Environmental Health and Engineering, Alaska Native Health Consortium.

As I told the first panel, your complete written testimony will be included in the record, but in order to give everyone equal time before we have to close it down unless you want to come back later this afternoon which most don't, I'd ask you to limit your testimony to about 5 minutes or less.

Why don't we ask the third panel to be seated too: Kay Culbertson, president, Denver Indian Health and Family Services; Dr. Everett Rhoades, Oklahoma City Urban Indian Health Clinic; and Carmelita Skeeter, executive director, Indian Health Care Resources Center of Tulsa.

Rachel, would you start. Remember we have about 5 minutes apiece.

STATEMENT OF RACHEL JOSEPH, COCHAIR, NATIONAL STEERING COMMITTEE ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Ms. JOSEPH. Good morning. My name is Rachel Joseph, chairperson of the Lone Pine Paiute-Shoshone Tribe and cochair of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. I'm also chairperson of the Toiyabe Indian Health Project a consortium of nine tribes serving California's Inyo and Mono counties.

Thank you for holding this joint hearing providing us an opportunity to state our strong support for S. 556 and H.R. 2440, the Reauthorization of the Indian Health Care Improvement Act. These bills contain provisions that are necessary to improve the ability of tribal and urban programs and the Indian Health Service to provide comprehensive, personal and public health services.

In 1976, when Congress found that "the unmet health needs of American Indian people are severe and the health status of Indians is far below that of the general population of the United States," the Indian Health Care Improvement Act was enacted. Federal health services to Indians and Alaska Natives has resulted in a reduction in prevalence and incidence of some illnesses. For example, since we delivered our proposed bill, the death rate for pneumonia and influenza decreased from 71 percent higher than all races in the United States to 52 percent higher.

However, the unmet health needs of our people remain alarmingly severe and continues to decline. Our health status, as already stated, is far below that of the general U.S. population. This crisis and disparity to be addressed is formidable.

The oral health of our patients is poor and we experience approximately three times the amount of tooth decay and periodontal disease than the U.S. general population. As already stated, the mortality rate for diabetes, 420 percent greater than the rest of the Nation, and Type II diabetes is rising faster among our children and young people than any other population and is 2.6 times the national average. Our suffering due to diabetic end stage renal disease is 6 times the rate of the national population and amputations due to diabetes is three and four times the rate.

In my community, diabetes is among the three top chronic diseases. We serve our population with three clinics and just at the Bishop Clinic, we see an increase of two diabetes patients every month.

Cardiovascular disease is now the leading cause of mortality among Indian people with a rate that is almost 2 times that of the U.S. general population.

The recent fully analyzed and racially adjusted mortality data [fiscal year 1999] from the National Center for Health Statistics documents an overall 4.5 percent increase rate for American Indian and Alaska Native people, from 698.4 per 100,000 population for the period 1994–96 to 730.1 per 100,000 for the period 1997–99.

In recognition of the conditions just reiterated, tribes engaged in the consultation with a goal to develop consensus and the NSC membership acknowledged that all of our constituents included the "lesser haves" the "least haves" and "have nots"; thus, we agreed not to "take from each other". One of our ground rules was that

"provisions will not adversely affect or diminish funding which is available to other Indian programs or the I/T/U system. . . "

Now, I will highlight title III of the bills which now provides a broader approach to address the unmet facilities needs and provides innovative funding options. Language concerning Safe Water and Sanitary Waste Disposal Facilities in section 302 of S. 556 reiterates a cooperative relationship between HHS and HUD regarding safe water and sanitary disposal. After consensus was reached on this issue, reflected in S. 556, there has been an effort by some housing advocates to amend the language that prohibits the use of I.H.S. funds for newly constructed HUD homes. Why do it since the I.H.S. Section 302 funding is already critically under funded for this "Safe Water and Sanitary Waste Disposal Facilities" program? Approximately 21,500 American Indians and Alaska Native homes lack safe water and the current backlog of need for this program construction is $900 million. Since 1982 Congress has repeatedly expressed its intent that funds appropriated to the IHS not be used for sanitation facilities for new HUD homes. This system worked fairly well until 1996 when NAHASDA was enacted and funding is now distributed by a formula which does not account for deficiencies or cost of offsite sanitation facilities. One of IHS Government Performance Results Acts [GPRA] indicators for fiscal year 2005 is to increase the proportion of American Indians and Alaska Natives receiving optimally fluoridated water by 0.5 percent over 2004 levels.

An IHS fiscal year 2002 indicator committed to a 5-percent increase of American Indian and Alaska Natives benefiting from fluoridated drinking water. While the fiscal year 2002 indicator was not fully achieved, 15 small systems not previously fluoridated became fluoridated adding 20,580 individuals to those receiving the benefits of fluoridated water. Since fluoridation is one of the most cost effective public health measures for reducing the prevalence of dental decay of all ages, we must do what we can to ensure that these limited funds remain available for these purposes.

If I may share a personal experience. This spring, the Indian Health Service replaced a water pump, replaced asbestos pipes, fluoridated our community drinking water and pressurized our system. Before that, my parents had to utilize water that would not allow for the brushing of teeth at the same time you washed dishes. My dad did not allow us to wash his dress shirts at home because our water was tainted with rust color. Now, the 228 young people in our community will experience the long term benefits of fluoridated water. The middle-aged and us elders will experience those benefits as well.

An IHS indicator, No. 35, for fiscal year 2005 is to provide sanitation facilities to 22,300 homes, in 2002, 15,255 homes were served. I support addressing the need and those tribes that are next in line to receive these services and I hope the dollars are there.

A new provision of S. 556, section 310 and section 309 of 2440 authorize a loan guarantee, a revolving loan fund and a grant program for loan repayment. The authorization to appropriate funds for an Indian health care facility loan program could be tremendous support to those tribes that want to build their own facilities.

The joint venture, section 312 of S. 556 and section 311 of H.R. 2440, provides for creative, innovative financing by tribes for construction of health facilities. This joint venture with the Indian Health Service is a viable option for those tribes that can construct their own facility. The IHS obligation is for equipment, staffing and to operate it.

In 2001 and 2002, Congress appropriated dollars for this program which resulted in the construction of four facilities which included two on the IHS priority list. The small ambulatory program, section 306 of 556 and section 305 of 2440, another popular program with the tribes, authorized in 1992, received its first appropriation in 2001 and 2002 of approximately $10 million which provided for the construction of 17 tribally owned facilities that the tribes equip, staff and operate. Unfortunately, neither S. 1391 or H.R. 2691 includes 2004 funds for this small ambulatory program. Another new provision "Other Funding" provides for alternative financing options.

The CHAIRMAN. Rachel, I apologize, but we are going to run out of time.

Ms. JOSEPH. The National Steering Committee appreciates this opportunity. We completed the process of consultation and collaboration with broad support and we want to urge you respectfully to consider any procedural actions necessary to move this legislation as quickly as possible.

Thank you for your time.

[Prepared statement of Ms. Joseph appears in appendix.]

The CHAIRMAN. Thank you.

Dr. Muneta.

STATEMENT OF DR. BEN MUNETA, PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Mr. MUNETA. Good morning.

I am president of the Association of American Indian Physicians. I would like to add our organization's support for the reauthorization of the Indian Health Care Improvement Act. I am somewhat reflective of our membership in that I worked in urban, tribal and Federal health care facilities and we have all come to the consensus that this Act is for the good of Indian people.

The Indian Health Service is a highly efficient organization. You can't find anything in government that is more efficient in the use of dollars as the IHS. We feel any money that is directed that way is money well spent by the Government.

I would add that American Indians are living longer but one of the big problems we see is in several cities American Indians are going to have the lowest quality of life of any minority group in this country. The reason is simple. Chronic diseases like diabetes are going to sap the health of Indian people. Diabetic patients are 4 times more expensive than a non-diabetic patient under usual medical care. This translates into people being sicker, not having jobs, and economic loss to the communities. It is a ripple effect throughout Indian communities, not just in the health care system.

One of the ways we look at these disparities is by training more Indian doctors, more health professionals who go back to these communities and provide long term, quality care. This is one of the

great success stories that we have, the health scholarships that IHS operates.

I think that is all I have to say.

[Prepared statement of Mr. Muneta appears in appendix.]

The CHAIRMAN. Thank you.

Mr. Weaver. I might mention Senator Murkowski had to preside at 12 p.m. She has already left but she did tell me that she particularly wanted to hear your testimony, so I am sure she will read it with great interest.

STATEMENT OF STEVE WEAVER, DIRECTOR, DIVISION OF ENVIRONMENTAL HEALTH & ENGINEERING, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM, ACCOMPANIED BY ANDREW JIMMIE, CHIEF, MINTO TRADITIONAL COUNCIL

Mr. WEAVER. Thank you for the opportunity to testify regarding S. 556 and H.R. 2440, the Senate and the House bills that would reauthorize the Indian Health Care Improvement Act.

I am appearing today on behalf of the Alaska Native Tribal Health Consortium where I serve as Director of the Division of Environmental Health & Engineering. I am accompanied by Chief Andrew Jimmie of the Minto Traditional Council who appears this morning in his capacity as the vice chair of the Alaska Native Health Board. Chief Jimmie is also the president of the Tanana Chiefs Council Conference of Regional Health Boards and recently received the prestigious Alaska Federation of Natives Health Award.

Under the leadership of the National Steering Committee, the language in what has been introduced as H.R. 2440 was developed in nearly complete consensus by tribal leaders. I am pleased to testify this morning that from a sanitation facilities operations perspective, I recommend to the Senate that it substitute the sanitation and facilities provisions of H.R. 2440 in place of S. 556.

I would particularly like to thank the committee for its long term support of the SFP program. Sanitation facilities construction is first and foremost about public health. It has a documented history of success in raising the health status of American Indians and Alaska Natives. While much as been accomplished, much remains to be done.

IHS estimates the current national unmet need both feasible and infeasible of Indian sanitation unmet need of $1.6 billion. Alaska's component is $640 million. Alaska has a unique and demanding living environment. Suvonga, displayed to your left, is typical of remote Alaska Native communities, accessible by air year round and in the summer by boat but it is not connected on land by any road network.

Cooper Bay is also typical of rural Alaska. For the last 40 years, they have packed in their drinking water and packed out their human waste in honey buckets. They are not atypical. One-third of Alaska Native homes still lack piped water and sewer facilities.

Other Indian communities throughout the United States face similar challenges. Current national funding levels are not nearly sufficient to make meaningful progress. The Indian Health Service sanitation deficiencies, unmet needs inventory is increasing at a rate of $50 million a year in addition to the construction activities.

The National IHS Priority List for new health facilities has stood without major addition for some 15 years. Language improvements in title III of H.R. 2440 represent an opportunity to provide flexibility in how we address this backlog and enhance how we do business. It establishes requirements to set priorities for limited facilities resources. It provides more flexibility of program management for tribes and the potential for innovation as tribes develop and diversify alternative funding sources. It enhances the ability of IHS and the tribes to deliver critically needed services as well as clarifying operational authorities.

It also provides the tribes a real opportunity to aggregate funding sources and to utilize those to the best opportunity of the community. The impact of public health is not in the construction of the facility, it's in the long term operations and maintenance of that facility to deliver the lifestyle improvement and the health improvements so badly needed.

In conclusion, I'd like to thank Chairman Campbell and Chairman Pombo and the respective committee members for this opportunity to give an engineer's perspective as we move forward together building healthy and safe American Indian and Alaska Native communities.

[Prepared statement of Mr. Weaver appears in appendix.]

The CHAIRMAN. Thank you.

Ms. Culbertson.

STATEMENT OF KAY CULBERTSON, PRESIDENT, DENVER INDIAN HEALTH AND FAMILY SERVICES

Ms. CULBERTSON. Good morning. My name is Kay Culbertson. I am an enrolled member of the Ft. Peck Assiniboine/Sioux Tribes from Poplar, MT; the executive director of the Denver Indian Health and Family Services; and also serve on the board of the National Council of Urban Indian Health.

I am honored today by the presence of my father and I am very happy he could be here with me.

Let me start by saying I'm not a lawyer or a policy analyst. My testimony both oral and written are from my heart and reflect a combination of my brief experience as a program director and my lifelong experience of growing up between the reservation and the city. Some of my testimony may sound strong but I find I must stress these issues or I would not be true to my upbringing and values I hold as an Indian person and as a wife and as a mother of three, all of whom are enrolled members of federally recognized tribes.

It is time that urban Indian health issues are seriously considered and I believe S. 556 is a good beginning. I would like to thank you for the improvements in the bill. The designation that a major goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians regardless of where they live to be raised to the highest level that is no less than that of the general population and to provide for the maximum participation of Indian tribal organizations and urban Indian organizations in the planning, delivery and management of those health services.

I would also like to point out at this point, the urban Indian health programs receive not even a full two percent but almost two percent of the Indian Health Service budget.

Some key points have been very positive for urban Indian health programs in this legislation, allowing urban programs to receive reimbursement from insurance programs when the urban Indian health provider is considered to be an out of network provider; the disregard of payments received through third party revenue and determining funding appropriations for health care and services to Indians; the ability of current programs to create satellite clinics to better address the health needs of the Indian community; the establishment of a self sustaining, revolving loan fund that will be solely for urban Indian health facilities; and permanency for the Oklahoma City and Tulsa demonstration projects.

The development and construction of two residential treatment centers for urban Indian youth in each State where need exists and where there is a lack of culturally constant residential treatment services for youth, as mental health and substance abuse needs continue to grow and State facilities and funding are cut, we must address these needs for the city youth.

Increased consultation with urban Indian health programs and Federal Tort Claims Act coverage for urban Indian organizations who receive funding under this legislation are also items of concern to me as an urban program director. Urban programs are not eligible to apply for chronic shortage demonstration projects. We experience shortages in personnel all the time through the urban Indian health clinics.

The sections that address the mental health training and community education programs as well as prevention control and elimination of communicable and infectious disease programs includes urban Indian programs and studies and consultation processes but do not include us in the development, technical assistance and funding of these programs.

Urban Indian health programs are not authorized to benefit from the Indian Health Care Improvement Fund or the Catastrophic Health Emergency Fund. Lack of funding authorization for critical services primarily home and community based services, public health functions and traditional health care in urban programs, we do use traditional health care.

Title VIII, which has been very hard for me, addresses the provision of health services to non-eligible persons. This is of great concern to me as a tribal member and all members who live off reservation. I believe it takes away services from legitimate tribal members regardless of where they live. It appears unfair that tribal members who reside off reservation are subject to minimal care while non–Indians on the reservation may receive comprehensive services and possible access to contract health care services.

On behalf of my community and all tribal members who live off reservation, I'd like to thank you for the opportunity to provide testimony on S. 556. I would like to close with this statement. The United States continues to have a legal obligation to fulfill with Indian people. Our ancestors, the people that live in the cities, also signed treaties with this Government that included provision of health care for their descendants in exchange for this great coun-

try. Whether an Indian lives off or on the reservation should not be an issue. These obligations should follow our people regardless of where they live.

If all urban Indian people were to return home today or even one-half of us returned home today, being we have over 60-percent of the population, and exercised our right to those health benefits, how would the Federal Government meet the trust and treaty responsibilities to Indian people?

Thank you.

[Prepared statement of Ms. Culbertson appears in appendix.]

The CHAIRMAN. Thank you, Kay.

Let the record reflect that not being a lawyer doesn't hurt you in the eyes of the committee.

Ms. CULBERTSON. Thank you.

The CHAIRMAN. We don't have an objection from Congressman Udall.

Dr. Rhoades.

STATEMENT OF DR. EVERETT RHOADES, OKLAHOMA CITY URBAN INDIAN CLINIC

Mr. RHOADES. Chairman Campbell, Chairman Pombo, members of the joint committees that are considering perhaps the most revolutionary health bill related to Indians that has been passed, my name is Everett Rhoades. I'm a member of the Kiowa Tribe. I was one of the incorporators of the original Urban Indian Clinic in Oklahoma City and I also had the privilege of being one of the outside witnesses that appeared in the deliberations of the original bill in 1975. I appeared as a predecessor to the imminent Dr. Muneta on behalf of the Association of American Indian Physicians at that time where our primary interest was in title I, the Indian manpower provisions as well as in the disparities.

I am here today on behalf of the Oklahoma City Urban Indian Clinic. Because of the importance of this hearing, I'm accompanied by our board president, Rufus Cox, a member of the Muskogee Creek Tribe of Oklahoma; our chief executive officer, Terry Hunter, a Kiowa from Oklahoma City; and our chief operating officer, Robyn Sunday, a member of the Cherokee Tribe in Oklahoma City.

Let me make two points in the interest of time. First, there is a general conception that the basic authorization for provision of health services to urban Indians, title V of the Indian Health Care Improvement Act, I do not believe that to be true and many other individuals do not believe that to be true either.

A reading of the 1921 so-called Snyder Act which really provides basic authorization for health services simply says at that time the Commissioner of Indian Affairs should expend such moneys as Congress should from time to time appropriate for various programs, including interesting language that says conservation of health and relief of distress and for physicians, for Indians throughout the United States and does not provide additional guidance.

It is my understanding that the enactment of title V went beyond simply the authorization of services to urban Indians but it defined the nature of those services, it defined the nature of the receiving entity and part of the consideration was to avoid what I would call

the intrusion of the Indian Health Services' program itself into urban communities recognizing that even by the 1970's, a dramatic diaspora of Indians into urban communities would really ultimately require the entire budget of the Indian Health Service.

As a result of all that, a new entity was created set out in the definition of paragraph (g) or (h) in section IV that says these programs are to be located in urban areas, to be run by a local urban Indian board which, in my opinion, distinguishes them from both Indian Health Service and tribal programs.

In that regard, we would ask that the Congress keep that in mind in its deliberations in regard to title V and we very strongly support the Senate language contained in section V.

In 1987, as a result of what I would call the growth and evolution of urban programs in this country, the Congress set two important demonstration programs into being in Oklahoma City and in Tulsa which further defined urban health care in these two demonstration projects, basically to determine whether or not they would be more apt to succeed if they received their funding from the hospitals and clinics account of the Indian Health Service rather than the urban account in title V but the contracts were still executed under title V, so they are hybrid programs with a peculiar special characteristic that should treat them in many instances as service units are now operating units.

The second point we feel strongly about in Oklahoma City is that we respectfully ask the Congress to direct that funds that are received in the Oklahoma area by virtue of the fact the entire State of Oklahoma is a contract health service delivery area and the populations in both Oklahoma City and Tulsa therefore are counted in those allocations, unfortunately with the present arrangement of distribution of those funds, both Tulsa and Oklahoma City receive a minority of the funds that their own populations generate. We believe the Indian Health Service would welcome direction from the Congress that the allocations of additional funds, particularly under Indian Health Care Improvement Act, should be treated as service units or operating units within themselves.

In closing, I would reiterate in regard to section 512, the Senate language I think is excellent. It really continues language that has been in place since 1992 and I would respectfully ask the House members if they would accede to the language of the Senate where there may be differences.

Thank you.

[Prepared statement of Dr. Rhoades appears in appendix.]

The CHAIRMAN. Thank you. Your institutional memory is of great value to the committee.

Ms. Skeeter.

STATEMENT OF CARMELITA WAMEGO SKEETER, EXECUTIVE DIRECTOR, INDIAN HEALTH CARE RESOURCE CENTER OF TULSA

Ms. SKEETER. Good morning and thank you for inviting me to make this presentation today. I am very happy to see that it is a joint hearing.

I'm the executive director of Indian Health Care Resource Center in Tulsa and I have been with this organization for 27 years, so it

is very dear to my heart. I have I hope a very good story to tell you on the demonstration programs.

I am citizen Potawotami enrolled in my tribe and very active. Becoming a demonstration project in 1987, we did that with the help of Indian Health Service, the Urban Directors, coming together and seeing how we could make sure these two programs existed even though urban programs nationally were zeroed out of the budget.

Because of IHS and the tribal people seeing our programs were so vital to the State of Oklahoma, they wanted to make sue we were able to continue, so we were put into the 01 of the budget, line item. Since then, we have been able to double our resources and in some areas, triple our resources. It was like opening a new door or opening a window to a home that had been very stale and unsupported. We were able to then start receiving GSA vans to do transportation for our patients, we were able to start getting health care providers from IHS, able to start purchasing medications from the GSA pharmaceutical contract, so it was opening a new door.

The program in Tulsa has a $2.5 million Indian Health Service budget. We have been able to turn that budget into over $6.5 million by contracting with other agencies competing with other Federal programs on grants and contracts. We have five contracts with the State of Oklahoma to provide substance abuse and mental health services. We are State certified. We are accredited through the Association of Accreditation for Ambulatory Health Centers.

We have a contract with the Cherokee Nation where they provide the WIC services in our clinic and have done so since 1979. We have a contract with seven other tribes in the State of Oklahoma, a program called BEACH which is through the State health department and CDC working with children on obesity, drugs, physical fitness, the prevention of diabetes and we are in three Tulsa public schools with gym teachers working with these children daily.

I believe that we are a very good partner with all the tribes in Oklahoma. We work very closely with them and our board is a community elected board, we have elections once a year. Any tribal member in Tulsa can run for our board. We have in the past had councilmen from the Creek Nation on our board, councilmen from the Cherokee Nation on our board. The tribes hold meetings at our facility. Oklahoma City and Tulsa are the only two urban programs in the United States that have been able to get new facilities in the past 25–30 years.

The facility in Tulsa is 27,000 square feet, the facility in Oklahoma City I believe is about 27,000 square feet. We have been able to do that because we have been able to collect Medicaid at the OMB rate because we are treated as a service unit. This makes us different than the other urban programs. We have been able to tap into this resource of Medicaid reimbursement. That has allowed us to expand our services.

Tulsa, we do not receive any IHS funds for dental but we are able to provide dental services by having one dentist because we are able to collect Medicaid at the OMB rate. We are able to have an optometry clinic, full-time optometrist because we are able to fund that with the Medicaid OMB rate.

I feel very proud of what we have been able to do in Oklahoma, the services we are able to provide. Our service population is

15,000 active patients at our facility. We have over 6,000 patient visits a month. I have a staff of 85. I have the largest mental health outpatient department in the State of Oklahoma for Indian people. We take referrals from all over the State. I have four clinical psychologists full time, two psychiatrists part time, one for children, one for adults; I have a developmental pediatrician part time and I have four counselors that work out of our behavioral health department. I have a full time pediatrician in medical, family practice physician assistant, nurse practitioner, so I have a very large operation in Tulsa. We work very closely and are very integrated with the entire health system of the city.

We carry a caseload of 120 to 130 OBs continually. I have a contract with an obstetrician that comes in 1 day a week to see those OBs and the mothers if they qualify or have third party reimbursement, they are able to deliver in the city. If not, we provide transportation for the mothers to Claremore Indian Hospital which is 30 miles away one way.

We are very entrenched in the community. We are 27 years old. We try to tap into every resource we possibly can. We work very closely with the tribes and I do support S. 556. I want to thank the Senators for honing the language that would protect us from sovereignty. We do not want to get into the sovereignty issue.

We serve over 150 tribes and as an urban program, we want to continue to serve that 150 tribes. We want to continue operating as a 501(c)(3) under a community elected board and have the board set the policies that run the organization.

As I say, I am very passionate about this program. I've been there 27 years. I started out as the resource coordinator, clinic administrator and I've been the executive director for the last 14 years. I feel very strongly and would be more than happy to answer any questions.

[Prepared statement of Ms. Skeeter appears in appendix.]

The CHAIRMAN. Thank you, Ms. Skeeter.

We have managed to keep it within the timeframe. I'm going to ask our colleagues to submit any questions in writing as I will because we have run out of time but would like to yield to Chairman Pombo if he has any closing comments.

Mr. POMBO. I want to thank this panel for your testimony. It was extremely informative and very valuable for the committee as we move forward with this bill. On behalf of myself and my colleagues in the House, I want to thank you for taking the time to come here and share your stories with us.

I do have a number of questions as my colleagues do and we will be submitting those to you in writing. If you can respond to those in a timely manner in writing so they can be included as part of the hearing, we would appreciate it.

Thank you very much.

Mr. PALLONE. Could I just ask a procedural question? I thought it was very valuable to have this joint hearing today. I don't want to suggest to our chairman what he should do on this issue but I know that the Senate committee is planning to have future hearings. Either we have our own or if not, if we could possibly continue this joint hearing idea, it is certainly a way for the House

members to participate and also for us all to continue with investigation of the issues.

The CHAIRMAN. I will have our staff work with Chairman Pombo's staff and see if we can't do that dealing with health care.

We will submit those questions and if you could get those back to in writing at your earliest convenience, that would be good.

I want to thank all the panels and we will keep the record open for four weeks on this particular hearing because we will be doing another on the same subject. Next week we will continue the series on health care.

This hearing is adjourned.

[Whereupon, at 12:17 p.m., the committees were adjourned, to reconvene at the call of their respective Chairs.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MIKE ZACHAROF, CHAIRMAN AND ANDREW JIMMIE, VICE CHAIRMAN, ALASKA NATIVE HEALTH BOARD

The Alaska Native Health Board [ANHB], established in 1968, is recognized as the statewide voice of Alaska Natives on health issues. With contributions from its member tribes and tribal organizations, ANHB has been active for 35 years as an advocate on behalf of health needs and concerns of all Alaska Natives.

On behalf of 229 tribes within the State of Alaska, and over 119,000 Alaska Natives, the Alaska Native Health Board strongly encourages Congress to support and enact H.R. 2440, a bill to reauthorize the Indian Health Care Improvement Act.

H.R. 2440 is an update to the 1999 National Steering Committee draft of the Indian Health Care Improvement Act. Over the last year, under the direction of Representative Young, the 1999 National Steering Committee draft reauthorization bill and the first House and Senate versions of that draft were examined and updated to respond to concerns expressed by the Administration to provisions contained in S. 212—the predecessor to S. 556—to resolve differences between the bills before the Senate and the House in the last session, and to consider tribal concerns that have arisen since 1999. This work is reflected in H.R. 2440.

We are pleased that Steven Weaver has been invited to testify regarding before this joint hearing of the Senate Committee on Indian Affairs and House Resources Committee regarding the provisions of Title M of the Indian Health Care Improvement Act. As Director of the Division of Environmental Health and Engineering for the Alaska Native Tribal Health Consortium, he brings to you a wealth of experience and technical knowledge. We strongly endorse the recommendations made in his testimony.

Reauthorization of the Indian Health Care Improvement Act is one of the highest priorities of the tribes in Alaska. We urge the earliest possible action.

PREPARED STATEMENT OF R. PERRY BEAVER, PRINCIPAL CHIEF, MUSCOGEE [CREEK] NATION

Chairman Campbell, Vice Chairman Inouye, and members of the committee.

Thank you for this opportunity to share some of my thoughts with you about S. 556, the "Indian Health Care Improvement Act Reauthorization of 2003." My name is R. Perry Beaver and I have served as the Principal Chief of the Muscogee [Creek] Nation for the past 8 years, and as a National Council representative for several years before that. I request that my written testimony be made part of the hearing record.

Due to my years of service to the Muscogee Nation and my residence in Tulsa County for many years, I am familiar with the many health problems faced by Native Americans in Oklahoma, including Creek citizens residing in the Tulsa urban area. I have also been a part of the development and implementation of Department of the Interior and Health and Human Services tribal 638 contracts and self-govern-

ance compacts under the Indian Self-Determination and Education Assistance Act ["ISDEAA"] amendments during the past decade. These programs have provided the Muscogee Nation with a great opportunity to identify the specific needs of its citizens and to administer programs for that purpose, including health programs. The Muscogee Nation has made significant progress in its development as a government and in making improvements related to the provision of health care due in part to the opportunities presented by the ISDEAA.

Unfortunately, S. 556 contains a proposed amendment to the Indian Health Care Improvement Act that would severely limit the Nation's ability to exercise self-governance in the area of health care. Section 512(a) would amend the IHCIA to permanently remove the Indian Health Care Resource Center, Inc. in Tulsa, OK ["Tulsa Clinic"] from the umbrella of self-governance and make it a permanent direct care program of the Indian Health Service. This would be accomplished by the following provisions in section 512 (a) of the bill:

Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

A large number of the Native American population in Tulsa are citizens of the Muscogee Nation and the Cherokee Nation. The northern jurisdictional boundary of a portion of the Muscogee Nation and the southern boundary of a portion of the Cherokee Nation encompass separate areas in what is now Tulsa County. The Nation has strong roots in Tulsa, which originated as a Creek Tribal Town in the 1830's. The Nation owns trust lands in Tulsa County and also still owns a one-hundred acre tract of land in Tulsa that has been recognized by Federal courts as "historic reservation lands." Our capital complex in Okmulgee is only 30 miles from Tulsa. Although the Muscogee Nation has not fully exercised its self-governance related to its citizens' health needs in the Tulsa urban area in recent years, it maintains a strong governmental interest in meeting the health needs of Indians within its service area.

The Tulsa Clinic has been existence for approximately 20 years, many years before Congress amended the ISDEAA to include self-governance programs that would enable Indian nations to exercise greater control over Federal funds formerly awarded to them under "638 contracts." During much of that time, the Tulsa Clinic has been providing health services to Native Americans in Tulsa as a demonstration project under the IHCIA. The Nation has not made a strong attempt to obtain tribal control of the provision of health services in Tulsa currently provided by the Tulsa Clinic for various reasons, including the Nation's concentration on development of its existing health programs and its recent conversion to funding through a self-governance compact. I believe that the indefinite continuation of the Tulsa Clinic as a demonstration project would be in the interests of Native Americans in Tulsa. However, the Muscogee Nation is opposed to making the Clinic a permanent program and permanently removing it from the authority of the ISDEAA. This would eliminate the Nation's ability to compact for IHS funding allocated for the needs of Indians in Tulsa. This would infringe on the Nation's sovereignty within its jurisdictional boundaries in a significant portion of Tulsa County. I believe that at some point in the not too distant future, the Muscogee Nation will be ready to take an even stronger role in the provision of health care in Tulsa. The proposed amendment would prevent the Nation from doing so, through what would be, in effect, a Congressional delegation of the Nation's governmental authority to the Indian Health Services and the Tulsa Clinic as its grant recipient. The Board of the Tulsa Clinic would be in a permanent position to make decisions which are better left to tribal governments.

I respectfully ask that this committee refrain from approval of S. 556 unless and until the offending language in section 512(a) is removed or amended. I have reviewed new draft language provided by the Cherokee Nation, and have no strong objections to use of that language, except to language that would make the Tulsa Clinic a "permanent program" within the Indian Health Service ["IHS"] direct care program. I suggest that the language in section 512(a) be revised to read as follows:

Sec. 512(a). TULSA AND OKLAHOMA CITY CLINIC—Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall—(1) remain demonstration programs within the Service's direct care program; (2) continue to be treated as service units in the allocation of resources and coordination of care; and (3) be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.

Thank you for this opportunity to provide this testimony to you today.

Testimony of

Kay A. Culbertson, Executive Director

Denver Indian Health and Family Services

Before the

Senate Committee on Indian Affairs

And

House Resources Committee

On Senate Bill 556,

Indian Health Care Improvement Act

July 16, 2003

Good Morning Senate Committee on Indian Affairs Chairman Ben Nighthorse Campbell, Vice Chairman Daniel Inouye, House Resources Chairperson Richard Pombo and other distinguished committee members. My name is Kay Culbertson; I am an enrolled member of the Fort Peck Assiniboine/Sioux Tribes located in Poplar, Montana. I am the Executive Director for Denver Indian Health and Family Services located in Denver, Colorado and also serve on the board of directors for the National Council of Urban Indian Health. On behalf of the many tribal members who reside off reservation, I would like to thank you for the opportunity to provide testimony regarding the proposed reauthorization of the Indian Health Care Improvement Act. There are currently 36 urban Indian health programs located throughout the United States, with each program offering a variety of medical services through many creative and innovative delivery types. For

today, I will focus on the impact of the reauthorization and proposed amendments to the Indian Health Care Improvement Act, S.556.

History

The legal doctrine associated with the federal trust relationship and other federal policies of this country serve as the legal basis for providing health services to American Indian people. The federal policies of this country have resulted in a significant population of American Indian people living in cities throughout this country.

Prior to the 1950s, most American Indian people lived on reservations or in tribal jurisdictional areas such as Oklahoma. In the 1950s and 1960s, the federal policies of the United States began to terminate its legal obligations to Indian tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs Relocation and Employment Assistance Programs which relocated Indian families from reservations to various cities across the country including Denver.

Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an Indian Health Service (IHS) facility service area, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to Federal Government relocation. The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated over 160,000 American Indians to cities.

As you know the 2000 census reports that 66% of American Indians live in urban areas. As opportunities for employment, education and housing become more strained on reservations we anticipate that these percentages will continue to increase over the next ten years. It should be added that the American Indian population is widely considered

the most undercounted group in the Census. Although the total number of Indians may actually be low, our experience is that the percentage of Indians living on reservations compared to those who reside on reservation is accurate.

Since Denver was one of the original relocation cities it has a significant Indian population. A segment of Denver's Indian population is a result of men and women who settled here after serving in the armed forces. Another segment came to Denver because at one time there was a Bureau of Indian Affairs area office located in the metropolitan area. Many Indian people moved from the reservation to the Denver area with the hope of attaining the "American Dream". Today, Denver continues to be a hub for Indian people. Denver's Indian population is estimated at 38,000 and is comprised of people who have lived in Denver for over 30 years producing 2nd and are 3rd generation Denver natives as well as those who are transient and move to and from the reservation on a regular basis. The primary reason for moving continues to be "hope for a better future".

Denver Indian Health and Family Services was created as the result of a needs assessment conducted by the Denver Native Americans United. Denver Indian Health and Family Services was incorporated in 1978, as a non-profit Indian organization and received funding from the Indian Health Service to provide outreach and referral services to the Indian community. With a staff of two people, the agency gathered and provided information to Indian people in accessing health care in the Denver metropolitan area. Eventually, DIHFS began to provide limited health care through volunteer nurses and doctors and grew into a full scale clinic entering into an agreement with Denver Health and Human Services. The number of uninsured and inability to charge American Indian patients placed a much larger financial burden on the organization and clinic services

were discontinued in 1991. Unfortunately, the health care needs of the community exceeded the funding limits of the agency.

In 1996, DIHFS entered into an agreement with a local community clinic to provide services at a limited cost; however, the agency could only allow two visits per year and the patients were responsible for their own laboratory and x-ray costs. This arrangement made it difficult to provide health care and much needed follow-up to persons with chronic medical problems such as diabetes. The community voiced the need for additional health care. Not just any health care but health care that was culturally sensitive and available through an Indian organization or provider.

At a 1998 strategic planning retreat for the DIHFS board of directors planted the seeds to begin the process of providing medical services to the Indian community on site. The board of directors stressed the importance of taking slow steps to providing health care. The board of directors insisted that the services be provided by DIHFS, that patients would receive more health education, that the delivery of services be provided in a manner that was comfortable to Indian patients, that the financial pitfalls of the past be avoided and that we maintain our identity as an Indian provider and an Indian clinic. In March of 1999, a young Indian physician, Dr. Lori Kobrine, took on the task of laying the foundation for our clinic. Through her efforts our clinic met the requirements for state licensure. She worked 20 hours a week providing limited medical services to the community. Our clinic continues to grow.

Since the spring of 2000 our clinic has been staffed with a full time nurse practitioner and a volunteer physician who provide medical services on a full time basis to the community. The medical services include immunizations, acute emergencies, well

child physicals, physicals, women's basic health, diabetes management and screening and other health services that do not require a specialist or may be life threatening. DIHFS also provides mental health and substance abuse counseling, substance abuse prevention, case management services for victims of crime, energy assistance, diabetes case management, diabetes prevention, weight loss support groups, fitness programs, prescription assistance, emergency dental, and referrals to meet other community health needs. In this short time, DIHFS patient load is over 2000 with over 280 Indian people registered with our diabetes program.

In providing services we have encountered barriers that tribes may not face. Ninety two (92%) percent of the patients seen in our clinic do not have absolutely no insurance, Medicaid, Medicare, or SCHIP included. It is interesting to note that patients who do have insurance and are not employed full time are retired military or federal service employees. Only 8% of our patients are employed full time and of those patients only 1.5% has health insurance. Often Indian people who come to an urban area have a misconception that urban Indian health programs are virtually the same as the Indian Health Service or tribal health programs on the reservation and may not elect to sign up for health care benefits. Colorado residents, as a whole, have found that many employers are no longer paying for health coverage benefits and they cannot afford the to pay for their own health care benefits, hospitals in the area are limiting emergency services for indigent persons to life and death situations. Our patients who have health insurance do not utilize their providers due to increasing co-pay amounts or deductibles. This leaves Indian patients with nowhere to go during an emergency situation that does is not life threatening i.e. a broken arm. We are often times the only safety net for Indian people in

the Denver area and our funding is severely inadequate and our services are limited in scope. DIHFS does not currently have an affiliation with a health maintenance organization (HMO) because we do not have 24 hour coverage nor hospital admission privileges. These issues also do not allow us to generate third party billing from Medicaid because the State of Colorado contracts with HMO's to provide services to the Medicaid beneficiaries.

Impact of S. 556

Overall, I wholeheartedly applaud the amendments included in S.556 with regard to improving the health status of American Indian people who reside off reservation in urban areas. Senator Campbell, the findings outlined in the beginning text clearly indicate that a major goal of the United States is 'to provide the quantity and quality of health services with which will permit the health status of Indians regardless of where they live, to be raised to the highest possible level, that is no less than that of the general population, and to provide for the maximum participation of Indian Tribes, Tribal Organizations and Urban Indian Organizations in the planning, delivery and management of those health services". The National Steering Committee agreed with those findings and went on to add that "population growth of Indian people that began in the later part of the twentieth century increases the need for federal health care services". Population growth in tribal and urban communities and the ever increasing move from tribal/rural communities to major urban centers must behoove both Congress and tribes to address the health needs of enrolled tribal members who no longer reside on the reservation but continue to maintain their tribal identity. The task of congress, Indian Health Service, tribal and urban Indian health providers is the same, to remedy the severe health

conditions of Indians, many of which were caused directly or indirectly by the United States. It can be argued that those treaty and trust obligations must extend to those tribal members who reside off reservation by force or choice. Although, this will not happen overnight, S. 556 has many improvements that will start to help in the elimination of health disparities for all Indian people.

Title I

Under the proposed language in Title I, Section 123, urban programs are not eligible to apply for chronic shortage demonstration projects. Urban programs are not immune to the same chronic shortages of health professionals that IHS and Tribal Health Programs face. I urge you to consider additional language in the title to include the urban programs as possible sites for demonstration projects.

Section 127, Mental Health Training and Community Education Programs includes urban Indian programs in the study of mental health providers that will develop the training criteria for those providers but fails to ensure that urban Indian health providers are included in the development and technical assistance for community education. This is a concern because any development or technical assistance for urban programs will ultimately result in a loss of services because we are often left out of training and technical assistance programs that are provided for tribal and IHS personnel. Any and all training dollars are taken out of direct service line items.

Title II

Urban Indian Health Programs are not authorized in the current or proposed legislation in sections 201 and 202 to benefit from the Indian Health Care Improvement Fund (IHCF) or the Catastrophic Health Emergency Fund (CHEF). Lack of authorization

for urban ICHF requires that urban programs divert funding from their current contracts to address community health needs or seek other funding sources outside of the Indian Health Service. If urban Indian health programs are authorized to access IHCF there would be more of a focus on development and provision of services to Indian patients versus the total patient population that also includes insured non-Indian patients who are seen in their clinic. IHCF for urban Indian health programs also would reduce the need for urban Indian health programs to diversify their funding sources to the extent that some programs have, e.g. one program has as many as 60 different funding sources. The administrative savings would benefit any urban Indian health program. Currently tribal members who reside in the Denver metropolitan area, without any type of insurance, who may happen to have a catastrophic illness or a victim of a disaster really have only three options 1. Seek care at their home reservation and wait for up to 6 months until the tribal/IHS contract health care eligibility guidelines apply; 2. Apply for Medicaid and other indigent care insurance; 3. Nothing.

Section 211 addresses the critical need for youth services regardless of where Indian children reside. Authorization for funding additional youth program services in urban areas is critically needed. Often urban youth do not have access to extended families or social ties that will help them to make the critical transition into adulthood. Urban youth are often marginalized in identity issues and experience conflicts in meshing their role in mainstream society and keeping a balance of their traditional beliefs and values intact. They often times suffer a much higher drop out rate. The dropout rate for American Indian youth in Colorado is 4.9% for males and 5.2% for females, the highest of any ethnic group identified and more than double the number of dropouts in the overall

population. We have found that many youth seeking our counseling services have a co-occurrence of depression with drug/alcohol problems.

In section 212, Prevention, Control, and Elimination of Communicable and Infectious Diseases, urban programs are included in the consultation and reporting processes but limits project and technical assistance funding available to tribes and tribal organizations.

Section 213 eliminates urban Indian health programs from authorization of funding for critical services primarily home and community based services, public health functions and traditional health care. These services are highly needed within urban Indian health centers. Although, the population may not be located in an isolated rural community, a need exists to be able to provide in-home care to elderly and disabled persons who are not able to navigate the urban area due to lack of transportation or failing health.

Title III

This section is limited to facility construction, maintenance and enhancement. Unlike tribes and Indian Health Service, both current and proposed legislation does not permit urban programs to participate in the facility priority system for funding of health clinics. Several urban Indian health programs have either purchased or built their own facilities through commercial loans, capital improvement funds or utilization of third party revenue received. However, these types of funding are often difficult to secure and most times not available to limited direct service and outreach/referral programs. This ensures that the community has a stable location. Urban centers that lease are faced with

increasing rental costs and no sense of ownership by the community. Programs that have had to move have found it very expensive and time consuming.

Title IV

This section speaks to the federal trust responsibility through the authorization to disregard payments received by tribes, tribal organizations and urban programs in determining funding appropriations for health care and services to Indians. In recent years Indian health programs have not received adequate funding to provide comprehensive services to Indian people. Although, it appears that appropriations have increased, these increases have not allowed for medical inflation increases, general inflation increases, salary increases or population growth.

This section also authorizes urban Indian health programs to recover reasonable charges for services for individuals who have private or public medical insurance. This is key for urban health programs to receive reimbursement from health insurance, Managed Care Organizations, CHIP, Medicare and Medicaid when the Indian patient is enrolled with the plan but the urban Indian health organization is considered to be an "out of network provider".

Title V

Title V is the heart and soul for the urban Indian health programs. This legislation created 36 urban Indian health programs and 12 urban alcohol a.k.a. "NIAAA" programs. The legislation also serves as the guidelines for creating other urban Indian health programs.

Items of note include the ability of current programs to create satellite clinics to better address the health needs of the Indian community. This is vital because many programs are located in large metropolitan cites such as Los Angeles, San Francisco, Chicago or Denver and have a large concentration of Indian people in their area.

Section 509 authorizes, for the first time, grants to these programs for the lease, purchase, renovation, construction or expansion of these facilities. It also establishes a revolving facilities loan fund that will be used solely for the purposes of urban facilities. The proposed fund would be self-sustaining. Facilities funding is a great need for almost every urban Indian health program. An important note in this section is that the urban programs do not have access to funds for maintenance and improvement of their facilities. The program in Boston currently resides in a very old State institution that utilizes skeleton keys for some of its offices. Denver Indian Health and Family Services recently needed additional office space and if it were not for the good fortune of my father being a construction contractor and volunteering his services along with a friend, we would not have had been able to add an office, a group therapy room, an additional examination room, a laboratory and another waiting area for medical patients.

Section 511 deals only with the issue of substance abuse; however throughout Title VII urban Indian health programs and urban Indians are included in this behavioral health section. Not to discount the substance abuse needs of urban Indians, it would better serve the urban Indians to be carried throughout Title VII because of its comprehensive look at both mental health and substance abuse issues for Indian people.

Section 512, the permanency of the Oklahoma City and Tulsa Clinics Demonstration project is vital. These programs have served as role models for other

urban Indian health programs. It is important to note that they have been able to retain their identity as "Indian Clinics" while still enjoying many of the benefits of being treated as direct care service unit. It is my belief that if tribes are able to contract these programs, services will become fragmented and the populations who receive care through these clinics will ultimately lose much needed health services.

The transference of Urban NIAAA Programs is authorized within section 513. These funds must be transferred immediately. These funds were scheduled to be transferred nearly 10 years ago. Because the NIAAA's have not been transferred the urban communities have lost much needed funding for the provision of substance abuse services. Several tribes or tribal organizations have contracted those funds and those monies are lost forever. It is urged that a moratorium be placed on the ability of the tribes to contract any substance abuse funds until the remaining NIAAA dollars are transferred. It is also urged that these programs should be designated as "Urban Indian Substance Abuse Programs" and thereby distinguish them from the Urban Indian Health Programs to ensure that duplication of administrative and granting authorities do not exist.

Section 514 provides for increased consultation between IHS, HCFA and other DHHS divisions. As has been demonstrated in other areas of Indian policy making, close consultation with Indian organizations leads to better results, less confusion and a higher level of cooperation and efficiency on the part of everyone involved.

Federal Tort Claims Act Coverage should cover urban Indian organizations who receive funding under through this title. This would appropriately grant the urban Indian organizations coverage that is currently enjoyed by other Indian organizations that receive federal funding. Elimination of the high cost of malpractice insurance lessens a

major barrier to outreach and referral programs in their efforts to become direct medical service providers. It also assists with defraying the increasing costs of medical malpractice for direct service providers and allows for already scare funding to be used for direct care.

Section 516 authorizes the development and construction of two residential treatment centers for urban Indian youth in each state where a need exists and where there is a lack of culturally competent residential treatment services for youth. It is vital to "catch" these youth in the early stages of behavioral health problems. Often times sending the youth to a tribal facility is not an option either because of distance or shortage of beds. As mental health and substance abuse needs continue to grow and State facilities and funding are cut, we must find a way to address these needs for our youth.

Section 517 allows for the Secretary of Health and Human Services to permit Title V funded organizations to use facilities or equipment owned by the federal government and authorizes the donation of excess property of the IHS or GSA to such organizations. This has the potential to greatly expand our capabilities and resources to urban Indian communities.

Section 518 Grants for Diabetes Prevention, Treatment and Control formalizes the existing diabetes authorizations in the Indian Health Care Improvement Act. Diabetes continues to run rampant in Indian people regardless of tribal affiliation and residential status. These grants have allowed urban programs to extend an increase of medical services to diabetics. In our clinic we have now weight loss support groups, a fitness training and facility, increased dental assistance, increased prescription assistance and more.

Section 601 establishes the Indian Health Service as an agency of the Public Health Service. The elevation of the department to an agency within the Public Health Service can dramatically serve to raise the awareness of Indian health issues within a vast bureaucracy.

Title VII

Urban Indian health programs are included throughout this title. As treatment modalities and research improve, it has become increasing more difficult to separate out purely substance abuse and mental health issues. The combined section of broader behavioral health will allow for greater flexibility in meeting the needs of Indian people with behavioral health issues.

This title also authorizes behavioral health treatment specifically for Indian women and fetal alcohol programs to be extended to urban programs for the first time. The special needs of Indian women, as well as the devastating effect of fetal alcohol syndrome are as common among the urban Indian population as the reservation population.

Title VIII

Section 807 addresses the health services that may be provided to non-eligible persons. This is of great concern to tribal members who live off reservation. It allows for non Indian step children and non Indian spouses to be receive services. Allowing access to already stretched services has potential to take away from legitimate tribal members regardless of where they reside. It appears wholly unfair that tribal members who reside off reservation are subject to minimal care while a non-Indian on their reservation may receive comprehensive services and possible access to contract health care services.

The establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement is welcome. Healthcare for Indian people must be viewed as an entitlement versus a discretionary program.

Distinguished gentlemen and ladies, on behalf of my community and all tribal members who live away from the reservation, I thank you once again for the opportunity to provide testimony on S. 556 and urban Indian health programs. I would like to close with this statement. The United States continues to have a legal obligation to fulfill with Indian people, our ancestors signed treaties with this government that included the provision of health care for their descendents in exchange for this great Country. Whether an Indian lives off or on the reservation should not be an issue. These obligations should follow our people regardless of where they may live. If all urban Indian people were to return home today and exercise their right to those health benefits how will the federal government meet the treaty and trust responsibilities?

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August 4, 2003

Senator Ben Nighthorse Campbell
Chairman, Senate Committee on Indian Affairs
Washington, DC 20510-6450

Dear Senator Campbell:

It was a great pleasure to offer testimony at the joint hearing of the Senate Committee on Indian Affairs and the House Resources Committee on July 16, 2003. I would also like to thank you for the opportunity to answer your questions and further clarify my testimony on behalf of Denver Indian Health and Family Services and urban Indian health care programs.

Questions

1. **In your testimony, you mentioned the high cost of medical malpractice insurance. IHS and tribal clinics and hospitals are currently covered by the Federal Tort Claims Act, are they not? What would be the dollar savings you would accrue if your clinic was similarly covered?**

IHS, tribal clinics and Community Health Clinics (330 programs)are covered by the Federal Torts Claim Act. It is important to note that 330 clinics are also located in urban areas and serve mainly the indigent populations. DIHFS is the only clinic in the Front Range that is charged with providing medical services to American Indian population and is not a 330 clinic.

At this point in time, DIHFS would save nearly $3000 this may seem a minor savings compared to other health providers, but the following points should be kept in mind; 1) We have a medical doctor that maintains his own medical malpractice insurance; 2) We do not have an MD on staff full time; 3) DIHFS utilizes a Family Nurse Practitioner; and 4) We are not a comprehensive medical provider at this point. These issues are key because medical malpractice costs and our limited funding have dictated the types of services we can provide. Not a day goes by in our clinic that we do not get calls for medical needs that most people take for granted such as prenatal, dental and broken limbs. .

2. **As I understand your testimony, 92% of your patients have no medical insurance coverage- private, state or Federal. Do you have any idea how much Medicaid billing your clinic could do, if it was allow to participate in Colorado's Medicaid HMO System.**

One estimate supports that we would be able to bill other providers for one third of our patients. As our mission states and my testimony made clear, DIHFS will only participate if we can limit our patients to American Indians and descendents. We have worked hard to maintain culturally appropriate services and provide quality care to the Indian clients in Denver. At a recent meeting with tribal providers, they mentioned how they regretted providing services to non-Indian patients. They had designed support programs for their Indian patients, but the support programs were also open to the non-Indian patients in their clinic. They told me that slowly the Indian patients stopped coming to classes and only non-Indians were attending.

3. **I noted with interest the mention of satellite clinics in your testimony. As you are aware, the Nighthorse Campbell Indian Health Center was recently located on the old Fitzsimmons base. How far is the Center from your clinic? Are there many Indians near there, that find it difficult to travel to your clinic?**

As you are aware, Senator Campbell, the Nighthorse Campbell Health Center does not provide direct services to the Indian community in Denver, although it is an invaluable research site. Ideally, the Center and DIHFS in their separate, valuable roles would both be fully funded and of great value to the Denver Indian community.

Senator Campbell, regardless of where one lives in the Denver metropolitan area, it is difficult to navigate the city. The Nighthorse Campbell Health Center is located approximately 30 miles from our present clinic. Although a satellite clinic is needed, we have not considered it as a priority because the community needs are so great. If DIHFS operated two fully funded and staffed clinics we could reach a much larger segment of the Indian population. A location near to the Nighthorse Campbell Indian Health Center could provide DIHFS and American Indian Alaska Native Mental Health Research staff the opportunity to collaborate on research and the urban Indian community in Denver. It is needed, because there is so little research and applied practice that pertain to urban Indian communities.

Locating at the Fitzsimmons site could also open the doors to students in the medical professions to gain experience working with American Indian people preparing them for possible employment with other tribal and urban Indian health programs.

I see Denver as the perfect location for a demonstration project. We are isolated from both IHS and tribal programs. What better place than Denver, with 38,000 Indian people, would there be for a demonstration project?

4. **I know that urban areas often attract Indian people from many different tribes and reservations. Can you give us an ideal of how many different tribes are represented among your list of patients?**

DIHFS provides services to members of more than 65 different tribes. The majority of our patients are **not** from the Albuquerque Area Office service area delivery. They yield from Montana, Oklahoma, California, Wyoming, South Dakota, Alaska and others. Although Denver is geographically isolated from most reservations and IHS/Tribal facilities, there is a large population who reside in the Denver metropolitan area.

If you need further information, please feel free to call me at (303) 781-4050.

Sincerely,

Kay A. Culbertson
Executive Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

CHARLES W. GRIM, D.D.S, M.H.S.A,

INTERIM DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS AND

THE HOUSE RESOURCES COMMITTEE,

OFFICE OF NATIVE AMERICAN AND INSULAR AFFAIRS

ON S. 556, A BILL TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT AND H.R. 2440, INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2003

July 16, 2003

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

July 16, 2003

Mr. Chairmen and Members of the Committees:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Gary Hartz, Acting Director of the Office of Public Health; Dr. Richard Olson, Acting Director, Division of Clinical and Preventive Services, Office of Public Health; and Rae Snyder, Acting Director of the Urban Health Office. We are pleased to have this opportunity to testify on behalf of Secretary Thompson on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003". And, at the Committee's request, I will discuss the health disparities, Indian health facilities and urban Indian health concerns.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally- recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities focused on health services for urban Indian people and addressed the construction, replacement, and repair of health care facilities.

We are here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. S. 556 reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthorization bill. IHS staff provided technical assistance and support to the Indian Tribes and urban Indian health programs through this lengthy consultation. However, we recognize that our programs overlap and have implications for other Federal agencies and their programs, and we are working with them to develop a comprehensive Administration position on this legislation.

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- Alcoholism – 770% higher
- Diabetes – 420% higher
- Accidents – 280% higher
- Suicide – 190% higher
- Homicide – 210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate health disparities plaguing our people for far too long. Although we have long been an organization that emphasizes prevention, I am calling on the Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Both field and tribal participation in the initial stages of planning and implementation is critical.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts that included massive vaccination and sanitation facilities construction programs. Unfortunately, as the population lives longer and adopts more of a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a rising rate that is significantly higher than that of the U.S. general population. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The IHS is working with other HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program. Also contributing to the effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. The primary focus is on the development of more effective prevention programs for AI/AN communities. The IHS has also begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs.

Diabetes mortality rates have been increasing at almost epidemic proportions. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The incidence of type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population, and is 2.6 times the national average. As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. Today I want to report to you that we may be seeing a change in this pattern however. In CY 2000 we have observed for the first time ever a decline in mortality. I must note that this is preliminary mortality data that needs to be thoroughly examined.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventative approach to diabetes management is an important consideration, since the cost of caring of diabetes patients is staggering. Managed care estimates for treating diabetics range from $5000-$9000 per year. Since the Indian health system currently cares for approximately 100,000 people with diagnosed diabetes, this comes out to a conservative estimate of $500 million just to treat this one condition.

Another area of concern is in behavioral health, specifically the identification and treatment of depression and strategies for prevention of depression. A recent study from Washington University in St. Louis has revealed that untreated depression doubles the risk for chronic diseases like diabetes and cardiovascular disease, not to mention the risks for alcoholism, suicide, and other violent events. This study also showed that of those individuals with chronic disease, unrecognized and untreated depression doubles the risk for complications of the chronic disease (e.g., amputations and renal disease in diabetics). We must find the best practices that will allow us to prevent depression primarily, or at the least recognize and treat it early if we are to reduce the disparities that affect Indian communities.

In summary, preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminated the disparities in health that so clearly affect AI/AN people.

Health Care Facilities

Title III authorizes the Facilities programs which construct, renovate, maintain, and improve facilities where Indian health services are provided. Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes where ownership of the facilities is turned over to the Tribes to operate and maintain them once completed. The IHS health care facilities program including the tribal programs, specifically, is responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services, with over 9 million square feet (850 gross square meters) of space. There are 49 hospitals, 231 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics which support the delivery of health care to our people. These facilities authorizations put in place the foundation on which health care delivery is provided to American Indians and Alaska Natives.

Health Care Facilities Needs Assessment & Report

Proposed provisions in the IHCIA reauthorization bills require IHS to report annually, after consultation with Tribes, on the needs for health care facilities construction, including the renovation and expansion needs. In fact, efforts are currently underway to develop a complete description of need similar to what would be required by the Bill. While not all the resource issues have been resolved, the process is in progress and the plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

Using Sanitation Facilities Construction Funds to Serve HUD Homes

Section 302(b)(3)(C) specifically proposes that IHS sanitation facilities construction funds will not be used to support service of sanitation facilities to Department of Housing and Urban Development (HUD) homes. The IHS is concerned that homes constructed using HUD funds include the necessary infrastructure to make a home complete, including safe water and sewer and wastewater disposal.

As you know, the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. We are committed to working with Tribes and other agencies to ensure that adequate facilities are planned for and funded in conjunction with new home construction, and we appreciate HUD's and other Federal agencies' willingness to work with us in this regard.

Classifying Long Term Leases as Operating Leases

Proposed provisions of the bills would make it possible to classify a lease for health care space as an operating lease and allow for long term leases for space (capital leases) to be scored against the budget in the first year of the lease. The intent of the proposed section is to make it possible for Tribes to acquire a facility and enter into a long term lease with the Government without having the full cost of the lease scored against a single year's budget. While this may make it possible for Tribes to more easily acquire needed space to house health care services, there is concern that leasing capital space in this manner will commit future Congresses and Administrations to funding without the opportunity for review.

Retroactive funding of Joint Venture Construction Projects

Changes proposed by the bills would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. An agreement implies that all parties have been party to the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient and/or ineffective to operate.

Sanitation Facilities Deficiency Definitions

Proposed new language in the bills, which provides definitions of sanitation deficiencies used to identify and prioritize water and sewer projects in Indian Country, is ambiguous. As written deficiency level III could be interpreted to mean all methods of service delivery are adequate to level III requirements (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) and only the operating condition, for example frequent service interruptions, make that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe that there should be a distinction.

In addition, the definition for Deficiency Level V and Deficiency Level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas,

level V should refer to an individual home or community lacking both water and wastewater facilities.

Tribal Management of Federally-owned Quarters

The bills reiterate authorization already provided in the Indian Self Determination and Education Act (P.L.93-638, as amended). We are concerned that slight differences in wording in the two bills either as written or in amendments could cause confusion. We believe that this proposed addition of unnecessary language should be deleted.

Threshold Criteria for Small Ambulatory Program

The Small Ambulatory Care Facility section contains proposed language that limits participation in the Small Ambulatory Program to facilities that provide more than 500 visits to eligible users and that provide ambulatory care in a service area with a population of more than 1,500 eligible Indians. These criteria are both lower limits and would apply to many facilities including all large health centers, most of which also qualify for priority evaluation and possible funding under Section 301 of the two bills. We are concerned that some facilities that meet these criteria may be of a lower priority than those on the Priority List submitted to Congress and could receive construction funding before higher priority construction needs. We do, however, see a need for a Small Ambulatory Program that addresses the needs Tribes with smaller facilities that do not meet the threshold to compete for placement on the Section 301 Priority Lists. For that reason we recommend that this section set an upper threshold criterion of 4,400 primary care provider visits for participation in the Small Ambulatory Program. The lower limit should be 500 primary care provider visits. The Small Ambulatory Program is to address the needs of small tribal facilities that are not competitive under the Section 301 Priority System because of their size.

Urban Indian Health

The Title V of the IHCIA provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to IHS. IHS currently funds 34 urban Indian programs nationally and these programs provide a range of services in three broad categories: comprehensive clinical programs; limited clinical programs; and outreach and referral programs.

In addition to the 34 urban Indian health programs currently in operation, the Congress has also authorized and funded the Oklahoma City Clinic and Tulsa Clinic Demonstration Programs. Both the Oklahoma City Indian Clinic and the Tulsa Indian Clinic (now the Indian Health Care Resource Center of Tulsa) were established in the early 1970's to serve the health and social needs of the urban Indian populations of Oklahoma. With the passage of the Indian Health Care Improvement Act in September 1976, these two programs were funded by the Indian Health Service (IHS) under Title V of that law as urban programs.

In 1978, the entire State of Oklahoma was designated as a Contract Health Service Delivery Area (CHSDA) by regulation (42CFR 36.22(a) (3)). As a statewide CHSDA Indian beneficiaries could reside anywhere in the state and maintain their eligibility for both direct services and contract health services. As a result of this change, the Oklahoma Indian population count for services was inclusive of all Indians residing in the state and counted as IHS beneficiaries in the IHS calculation for resource requirements and allocations.

The 1992 amendments to IHCIA provided for the establishment of two demonstration projects with the Tulsa and Oklahoma City clinics, "to be treated as service units in the allocation of resources and coordination of care." In establishing these demonstration projects Congress undertook a new and innovative approach to ensuring health services were accessible to all eligible populations in Oklahoma.

These demonstration projects have now established a "hybrid" system within the IHS and have a unique status. The projects are not operated strictly as an IHS facility or tribal contracted or compacted program or an urban program. Each program maintains its status under the Title V as an "urban Indian organization." Contracts are signed by the projects with the IHS, under Title V and the Buy Indian Act authority, yet the programs function like other IHS service units and report on the Resources and Patient Management System of the IHS with data utilized for inclusion in the allocation of resources. This unique status has allowed for a substantive increase in funds to the projects from the IHS based upon workload data and increases derived from substantial line-item funding increases directed by Congress in fiscal year 1994 addressing facility problems at each site. Both service population and overall utilization of services has dramatically increased since these programs became demonstration projects and as a result of the line item funds. They have been able to use the best of both urban and IHS structures to build a community controlled, high quality health system in a state designated as a contract health service delivery area.

On the other hand this hybrid system has raised a few concerns with some Oklahoma Tribes that operate their own health programs under the Indian Self Determination and Education Assistance Act, P. L. 93-638, as amended. The issue in most basic terms is allocation of resources for tribally administered services and urban provided services for closely located beneficiary populations. In an environment of resources reduced by a growing population and greater health need, the perception of a unique or special status may cause more concern than has been observed in the past.

While the challenges for the urban Indian health programs are many, they are much the same as those faced by the Tribes and the federal operations. Our work is to assure that we all are working to fulfill our roles in the I/T/U partnership and in collaboration to raise the health status of our Indian people.

Negotiated Rule Making; Tribal Consultation; Administrative Burdens

While the Administration continues to have serious concerns about the proposed bills in their current forms, we are committed to working with the Committees on legislation to reauthorize this important cornerstone authority for the provision of health care to American Indians and Alaska Natives.

We are concerned that both bills would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCIA. Negotiated rule making is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian provider input in the development of IHCIA rules and regulations in a given case.

Additionally, while we appreciate the value of consultation with Tribes, we have concerns about the consultation requirements. The bills would require Tribal consultation prior to the Centers for Medicare & Medicaid Services (CMS) adopting any policy or regulation, as well as require all HHS agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a State, that may affect such organizations or urban Indians. Such requirements appear to be broader than the existing Tribal consultation requirement and would be very difficult to administer, given the hundreds of regulations and policies potentially covered.

We have similar concerns about the considerable indirect adverse impact of the proposed new extensive reporting requirements and other administrative burdens on IHS and CMS would divert limited resources from other activities. As IHS programs and both IHS and CMS administrative functions are funded by capped discretionary accounts, the imposition of additional administrative duties on IHS and CMS would have the practical effect of requiring cutbacks in current activities.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments on other provisions, particularly in Title IV. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committees, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.

Joint Hearing Before the
Senate Committee on Indian Affairs and
the House Resources Committee, Office of Native American and Insular Affairs
on S. 556, a bill to reauthorize the Indian Health Care Improvement Act and
H.R. 2440, the Indian Health Care Improvement Act Amendments of 2003
July 16, 2003

1. Dr. Grim, I agree with your assessment of the need for preventive efforts to combat the diseases ravaging Indian communities, such as diabetes and cardiovascular disease.

What specific proposals do you have to change the focus from treatment, and begin addressing prevention?

ANSWER:

I have identified as one of my eight priorities an initiative on Health Promotion and Disease Prevention in order to eliminate health disparities. The main focus for eliminating disparities will be in our collective ability to develop and implement programs that will prevent disease, not focusing exclusively on treatment of disease. Some of these strategies include:

- Traditional practices and values have a very strong role in promoting wellness and we are identifying models of effective implementation of such programs (e.g., promotion of breast feeding and language and cultural training in early childhood and elementary settings).
- We have developed a web site with health promotion/disease prevention best practices that will provide information to Federal, Tribal and urban programs.
- Patient safety, quality of care, and access to care are also linked to this initiative. We are trying to get the electronic patient record available to both Federal and Tribal programs in order to give patients greater control and simplify their access to health systems, as well as improve safety and quality.
- The IHS Health Promotion Initiative is being coordinated with the Secretary's "Steps to HealthierUS Initiative" and Tribes will be participating in both Initiatives.
- Professional health experts, Federal leaders, Tribal leaders, and community leaders are engaged through the Health Promotion Task Force and Policy Advisory Committee to guide the Initiative to eliminate health disparities.
- Tribes and the Agency have identified Health Promotion and Disease Prevention in their health priorities for the FY 2005 budget.
- Funding is being provided for Area Prevention Officers in FY 2004 to coordinate primary prevention clinical and community based efforts.

Since IHS is a primary health care agency, we will, of course, have to continue to focus on treatment of individuals with diabetes and cardiovascular disease (CVD). However, with the Special Diabetes Program for Indians funding in 2004, the IHS is developing a new $29.5 million competitive grant program focusing on prevention of type 2 diabetes and prevention of CVD risk factors (hypertension, dyslipidemia, tobacco use, obesity, etc). This challenging undertaking will use the most recent research findings about "what works" in prevention of these conditions and translate those into the real world settings of American Indian and Alaska Native communities. Evaluation will be a key component of these large programs so at the end of this 5-year project we will be able to demonstrate the feasibility of prevention of type 2 diabetes and CVD in our communities.

A major success has been the entry of the Indian Health Service into the Healthy People 2010 CVD Prevention Partnership with the American Heart Association, CDC, NIH, CMS and DHHS, developing the ability to focus significant national expertise and shared resources on the prevention of CVD within American Indian communities. Currently, this partnership is involved with a number of the projects.

A national Roundtable on CVD Prevention will be held in Washington, DC on September 25 and 26, 2003, bringing in Tribal leaders as well as outside experts (including the American Heart Association, the American Diabetes Association, the American College of Cardiology, NIH, CDC, DHHS and academicians). The purpose of the Roundtable will be to develop a 5-year strategic plan for the prevention of CVD within Indian communities.

The IHS and the NIH, National Heart, Blood and Lung Institute, began a partnership in 2002 to address cardiovascular disease in Indian Country through interventions targeted towards the community. These preventive measures address CVD not only at the community level, but also in our I/T/U(s) hospitals and clinics on the primary, secondary and tertiary level. There are five communities located in Alaska, Oklahoma, and New Mexico that are pilot prevention sites. Each community received funding to support community-directed activities. Accountability is tracked through a web-based Community Health Assessment and via five GPRA+ CVD Indicators (BMIs, blood lipid testing, tobacco cessation, exercise and diet education, and hypertension). The IHS will again partner with the NIH on the second phase of the project, which is to provide a broad-based CVD awareness and training on CVD in December 2003. Approximately 75 Indian community staff will be trained to further expand the project to 6 regional train-the-trainer conferences in different regions of the US in 2003-2004 and subsequent dissemination with plans to develop prevention efforts and trainings in more than 100 Tribes and urban Indian communities.

The Indian Health Service is participating with NIH in the "Stop Atherosclerosis in Native Diabetics" (SANDS) project, a five year multi-center scientific evaluation of the benefit of more aggressive secondary prevention of CVD among those at the highest risk, those individuals with diabetes.

Finally, a number of our efforts have been focused on the development of clinical reminders of appropriate CVD prevention interventions during clinic visits, including lipid and blood pressure control as well as educational reminders for patients, integrating with our patient registration management system. In addition, the Indian Health Service, currently working with the American Heart Association, has developed and implemented an alpha test site for an appropriate model of the national "Get With The Guidelines" program to assure appropriate secondary prevention efforts are made by providers at the time of hospital discharge. The infrastructure for evaluation of our effectiveness in these areas is also in development with expectations of implementation within the next 12 months.

The Indian Health Service hospitals and clinics are moving toward improved prevention efforts through the increased provision of patient education to all clients by all providers. This project is now in its fifth year of emphasizing the importance of education to our clients. IHS has devoted resources for the development of this project that encompasses all disciplines and many of our reporting software packages have incorporated the Patient Education Protocols and Codes that enables the IHS to track progress in the area of education.

The IHS has partnered with the Centers for Disease Control and Prevention to increase community tobacco cessation awareness through the establishment of Tribal Tobacco Centers of Excellence. The IHS is now moving forward to begin to develop clinical standards of care through the establishment of a national clinical workgroup to address tobacco use in our hospitals and clinics. Certainly, some of our tasks will include developing standards of care for "tobacco use clients" that will include education, counseling efforts, life style adaptations, and nicotine replacement aids.

The Indian Health Service has developed a comprehensive, public health oriented program to address community-based injuries. The program emphasizes community-based epidemiologic assessment of injuries, development of community capacity to address injury problems, and funding to assist Tribes in addressing their injury issues. Starting in 2000, the Indian Health Services provided $1.475 million in competitively awarded cooperative agreements to 36 Tribal programs for the development of Tribal injury prevention infrastructure and implementation of proven prevention strategies. Since the late 1980's, the Injury Prevention Program has developed and offered a comprehensive training program to develop the capacity and skills of public health professionals and community practitioners. This sustained training strategy has resulted in a broad based cadre of community practitioners that are making progress in the reduction of the burden of injury faced by American Indians and Alaska Natives. The injury hospitalization rate for AI/AN has declined 68 percent since the late 1980's, the injury health disparity gap for AI/ANs is improving.

2. In this era of budget deficits and combating terrorism, pushing to enlarge the IHS is going to be hard. Additional resources must be coupled with creative funding mechanisms.

You mentioned concerns with IHS accepting inefficient or ineffective facilities under the Joint Venture Program. **How can we insure the quality of facilities without sacrificing the ingenuity of tribal efforts to get badly needed facilities up and running?**

ANSWER:

Many tribes have constructed health care facilities without any agreement with the Federal Government. However, under the Joint Venture Program the IHS provides the medical equipment and is authorized to lease the facility to provide IHS funded health care services. In order to participate in the facilities construction Joint Venture Program, approved planning documents are required to ensure all parties to the Venture have the same expectations regarding the nature of the participation of each participant. Obtaining these approved planning documents prior to construction is consistent within the facilities construction program and will help ensure that the equipment provided is consistent with IHS planning standards used in other construction projects.

Under the Joint Venture Program a Tribe agrees to acquire a facility and lease it to the IHS for 20 years at no cost. In return the IHS agrees to equip, staff, and operate the facility. This means that the tribe agrees to put up a one-time acquisition cost and that the IHS agrees to request funding for subsequent annual costs for staff, supplies, repair, and maintenance. Historically, even in most costly facilities, these annual costs are far greater than the initial cost to acquire the space. In facilities that are improperly planned and designed, these long term costs could be even greater.

IHS standards recognize the cost effective and energy efficient use of materials and systems to minimize maintenance and operating costs. Facilities that do not meet agency standards would result in reduced life expectancy of building systems and higher maintenance and operating costs.

Tribal ingenuity should not be sacrificed as long as program requirements are agreed upon and met.

Questions have been raised about lifting the restriction on use of IHS funds for sanitation facilities construction for new HUD-built homes. **Is there a way to provide greater flexibility, without creating unintended consequences to the sanitation facilities "priority construction list"?**

ANSWER:

The IHS is continuing to work with HUD, the Tribes, and Designated Tribal Housing Authorities to address this issue. Currently, IHS' appropriations language prohibits use of its sanitation funding for HUD built homes. If this restriction were not in place, giving IHS the added responsibility of providing sanitation to HUD built homes would reduce funding available for the Sanitation Facilities construction priority list. Funding is available to improve access to resources Tribes have not traditionally used, such as HUD's State Community Development Block Grant program and other Federal

programs. IHS is also developing training for IHS and tribal engineers and planners scheduled for early 2004, to increase capabilities in this area.

3. I remain concerned about the short shrift urban Native people receive, when 57% of Natives live in urban areas. Their needs must be addressed.

Is the answer to create more demonstration projects, like the Oklahoma urban clinics?

ANSWER:

The Indian Health Service is also concerned with the level of services we are able to provide for the American Indian and Alaska Native (AI/AN) people residing in urban areas.

Two types of services are provided by the Indian Health Service: (1) Direct health care services, which are provided by an IHS facility, or (2) Contract Health Services (CHS) which are purchased and provided by a non-IHS facility or provider. The eligibility requirements for who may receive services, as defined by law, are much more stringent for CHS than they are for direct care. CHS services are made available to the members of an Indian community who reside in the geographic area, referred to as the contract health service delivery area (CHSDA). The CHSDA is determined by: reservation boundaries; counties that include all or part of a reservation; and any county or counties that have a common boundary with a reservation; or states that are designated as a CHSDA. The entire state of Oklahoma has been designated as a CHSDA. Thus, the current urban demonstration projects in Oklahoma have CHS eligible populations they serve. Only two other states currently have that same statewide-CHSDA status and those are Nevada and Alaska.

As a result of the special demonstration project status for the Oklahoma City and Tulsa clinics, the designation as "service units in the allocation of resources and coordination of care" has allowed them the benefit of participation in the resource distribution of Hospital and Clinic funds and other IHS line item funding allocations.

Let me ask you a technical question that is being raised in urban funding. **What does a "compactible, but not divisible" service unit mean to IHS?**

ANSWER:

All program, functions, services and activities of the IHS that are not inherently Federal (i.e., functions that cannot legally be delegated to Indian tribes) can be contracted under the provisions of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. Essentially this means that all service units of the IHS can be contracted by tribes and are divisible in those situations where a service unit serves more than one tribe. A tribe can contract for that portion of a multi-tribal service unit that provides health care to its members. It should be recognized that in some limited

circumstances Congress has established exceptions to the "divisibility" of IHS programs. For example, Congress has directed through statute that the Alaska Native Medical Center (ANMC) cannot be contracted and divided by individual tribes because ANMC serves as a single medical referral center for all tribes in Alaska.

If, for arguments sake, a tribe were allowed to compact the Tulsa urban Indian clinic, and then later decided to retrocede that commitment (as allowed under P.L. 93-638), who would be responsible for servicing those Indian patients?

ANSWER:

The responsibility would return to the IHS. The retrocession of Federal programs by Indian tribes is governed by P.L. 93-638, as amended, and 25 CFR 900.240-45.

4. There is often a large gap between what Tribes believe "consultation" means, and what Federal agencies believe. Negotiated rulemaking has been one way to bridge that gap, albeit and expensive one.

Do you have suggestions on how to achieve the goals of negotiated rulemaking by a more economical means?

ANSWER:

Negotiated rulemaking (Neg/Reg) provides both structure and process for consultation on critical policies such as published regulations. It is a process that the IHS has successfully employed in the regulations drafting process which brings together those parties who would be affected by a Final Rule. A negotiated rulemaking committee is chartered as an advisory committee under the Federal Advisory Committee Act (FACA) to reach consensus on some or all aspects before the rule is formally published as a proposal (i.e. NPRM).

Although the Neg/Reg process itself is more expensive than the traditional process for the development of proposed rules, we believe there are advantages to the Neg/Reg process. Because representatives of all interested parties draft the rule, the formal process of public notice and comment is generally very smooth and very few comments and concerns are raised in that process. Also, lengthy rulemaking litigation is generally eliminated and compliance with the rule is believed to be much higher because of the participatory nature of Neg/Reg. In summary, although the cost of the Neg/Reg process itself is regarded by some as expensive, the costs associated with such a process are recovered in the quality and benefits resulting in the development of a final rule, such as clarity that avoids costly litigation. In some instances, however, negotiated rulemaking may not be the most effective way to obtain necessary input from Tribes.

It is my understanding that Tribes have agreed to forgo the negotiated rulemaking proposal as it applies to the Center for Medicare/Medicaid Services, by using a less

formal, but permanent, working group. **Is that something that would work for IHS as well?**

ANSWER:

The Center for Medicare/Medicaid Services (CMS) is currently in the process of establishing a Tribal Technical Advisory Group (TTAG) that will serve as an advisory body to CMS and provide expertise on issues affecting the delivery of health care for American Indians and Alaska Natives in programs administered by CMS. It is not the intention of the CMS or IHS to use the TTAG as a formal negotiated rulemaking committee. We would note that the Senate version of the IHCIA Reauthorization bill includes a provision for negotiated rulemaking language, a separate negotiated rulemaking committee will have to be established to carryout negotiated rulemaking requirements in reauthorization.

The IHS has also effectively and efficiently used workgroups on agency-wide policy consultation on those matters that do not rise to the importance of published regulation. These workgroups are not subject to FACA and therefore are less costly form of consultation.

5. There has been a great deal of discussion over the years about making Indian health an entitlement.

Does the Administration have any views on this issue that you can share with our Committees?

ANSWER:

The Administration has not formally studied the issue of making Indian health an entitlement. There are, however, Senate and House provisions in the Indian Health Care Improvement Act Reauthorization of 2003 that would establish a National Bi-Partisan Commission on Indian Health Care Entitlement and that would make recommendations to Congress for providing health services for Indian persons as an entitlement.

As you well know, Oklahoma has long been a "contract health" state. **Since that more closely links dollars with service population, is expansion of contract health to more regions an alternative to pure entitlement?**

ANSWER:

With respect to the issue of expanding CHS delivery areas as a substitute, I do not believe that is a viable alternative.

Joint Hearing of the Senate Indian Affairs Committee and the House Resources Committee on S. 556 and H.R. 2440, the Indian Health Care Improvement Act Reauthorization of FY 2003
Submitted Questions

Questions from Representative Napolitano
For the Administration:

1. **Is there currently a strategy/plan which exist to address the high alcoholism rate among Native Americans?**

2. **What is the current plan, if any, being implemented to address this problem of alcoholism?**

ANSWER:

Alcohol and substance abuse have and continue to be one among the most pervasive individual and public health concerns in Indian Country. Their effects are widespread, pervasive, debilitating, and highly resistant to intervention. Critically as well, they are not only personal and public health problems, but far reaching social problems affected by wide disparities of economics; education; opportunity; and self sufficiency. While the Indian Health Service is taking a leadership role in combating alcohol and substance abuse as a public health problem, it requires a comprehensive federal approach, with appropriate resources to fully understand the reasons for the high alcoholism rates among American Indians and Alaskan Natives and rectify the problem.

Currently approximately 97% of IHS Alcohol and Substance Abuse Program (ASAP) funds directly support tribally administered programs through contracts and compacts in accordance with P.L. 93-638. The tribes and tribal programs now decide how best to protect and treat their own people and communities given the resources provided by federal, state, and tribal governments. The future, then, of alcohol and substance abuse programs rests with the tribes and tribal/urban programs. Given this situation, IHS has adopted a national approach designed to help these programs help themselves and to collaborate with those other federal departments and agencies that have resources to assist in the efforts. Approximately two years ago IHS utilized its convening capability to begin a national tribal consultation among federal, tribal, state, and urban programs. This process, which took over a year and a half, was driven by and for tribes and tribal programs. It allowed them to define what they saw as the most pressing needs in Indian Country, to make recommendations for distribution of new congressional funding allocations earmarked for ASAP programs, and to develop long term strategies to address their needs nationally.

The resulting Five Year National Strategic Plan on Alcohol and Substance Abuse was adopted by the IHS Director, without change, as the ASAP goals of the

Agency in January, 2003. In addition, the Director also approved the congressional funding allocation recommendations and the recommendation to create a National IHS Advisory Committee on Alcohol and Substance Abuse to help guide the Agency and national ASAP efforts. This is a landmark achievement as it represents a positive collaborative effort among multiple federal, tribal, state, and urban programs to agree upon approaches and intervention strategies in ways they had not been able to do previously.

The Five Year National Strategic Plan represents the broad interest areas that the national tribal leadership saw as the most pressing to address:

1. Improve Trends, Data, Research and Technology Capability
2. Develop Alternative Funding Sources
3. Promote Community Education, Awareness and Prevention
4. Foster Professional Development
5. Implement a "Call to Action" and Leadership Development
6. Develop Partnerships
7. Provide Innovative Intervention, Treatment and Aftercare

The National Strategic Plan is then operationalized in the following specific programs. The programs below are a representative sample of the comprehensive approach. As in the overall strategic approach, IHS is acting as liaison, convener, and coordinator for diverse agencies and organizations to work together on behalf of American Indians and Alaskan Natives:

- IHS is lead agency for the Memorandum of Understanding between DHHS and Health Canada, signed in FY 2003, to promote program partnerships and collaborative efforts between the two countries. Significant progress has been made in what is being called the "4 P's" of collaboration between the two countries: establishing "Principles" of collaboration; "Processes" by which those principles can be implemented; and "Products" and "Programs" which will be created as a result of those processes. Principles and processes of collaboration have been mutually agreed to and now the focus is on products and programs. Three major program areas have been identified for collaborative work: suicide; FAS/FAE; and cross border issues, including care across borders. Work teams have been identified and work has begun on forming programs to be implemented in FY2004. The collaboration has already provided very rich cross pollination of ideas and programs that otherwise would not have been possible. The programs currently being planned reflect that richness.

- IHS ASAP is collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease

Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Bureau of Indian Affairs (BIA), Department of Housing and Urban Development, Department of Transportation, Administration on Aging, and the Department of Justice (DOJ). The following items are a partial list of those activities.

- In FY 2003, all NIAAA programs were successfully migrated to IHS Urban Health Programs.

- Continue coordination with the CDC to fund an injury management control officer and a tobacco education and training officer.

- Continue to work with the Office of National Drug Control Policy, the Department of Transportation, Bureau of Indian Affairs, Department of Justice, and the Department of Housing and Urban Development to co-sponsor and develop an annual national Tribal leaders best practices in substance abuse summit.

- Continue a focus on services to elders and to people with disabilities, which have been part of the behavioral health activities since FY 1999. In FY 2001, the IHS designated a steering committee comprised of representatives from the IHS and CMS. In FY 2002, the IHS coordinated with the Administration on Aging and the National Indian Council on Aging to host the first American Indian and Alaska Native Roundtable on Long-Term Care. The final report is available. The IHS in FY 2003 continues to be actively involved in work to meet the objectives of the President's New Freedom Initiative to relieve and eliminate barriers to employment and quality of life for people with disabilities (PWD). Currently the agency is working to increase the employment of PWD and to develop the appropriate workplace accommodations for PWD although no funds have been provided for this initiative.

- IHS is devoting $1 million per year for five years, with the potential for continued funding at that level, to develop information technology hardware, software, and infrastructure throughout Indian Country that will support direct patient care to large scale research studies.

- IHS participates in an interagency collaboration with SAMHSA to jointly address alcohol and substance abuse in Native populations. Two IHS personnel are assigned to SAMHSA for a total of four days per week to provide a liaison between the respective agencies

and advocating for needed resources by our constituent populations. In addition, the IHS liaisons are promoting IHS directives, or priorities, to CSAP and CSAT.

- Over the last three years IHS has worked with SAMHSA to coordinate efforts among the various divisions in both agencies as well as among the tribes and urban groups nationally to maximize resources. This collaboration includes an annual national conference bringing together federal, tribal, state, and community members from across the country to develop specific plans and partnerships in all 35 reservation states, as well as urban programs across the country. The last conference in June, 2003, drew over 300 people representing tribal groups; multiple federal departments and agencies; 21 reservation state representatives; and urban programs from Alaska to Florida. A total of 64 specific follow-up activities were recommended by the participants for region specific action; the most notable being increasing collaboration, increasing training opportunities in counselor education, planning, coalition-building, and more family-centered program initiatives that focus on education. Participants noted the need for more programs supporting collaborative strategies at the state and local level, increased ability of states to work with tribes on a 'government-to-government' basis, and the need to include domestic violence, prevention strategies, and addictive gambling as topics for future discussion.

- At the conference, SAMHSA announced the award of a three year, $3 million grant to establish a Native American National Substance Abuse Center to provide a research and technical assistance clearing house to all tribes and urban programs nationally.

IHS provides guidance, technical assistance, and monitoring to CSAP and CSAT in responding to the White House Initiative Executive Order for Tribal Colleges and Universities.

3. **Which studies, if any, have been completed or are underway to address alcoholism within the Native American community?**

ANSWER:

There have been hundreds of studies and research efforts undertaken over decades to seek to understand the nature, severity, causes, and correlates of Native American alcohol and substance abuse, as well as treatment efficacy and effectiveness. Those studies cover a wide range of topics, viewpoints, methodological approaches and methods of analysis. Also, like many other areas

of research in Indian Country, there is a wide range of validity and reliability present in them as well. Major university programs—among them notably are the universities of New Mexico; Colorado; Oklahoma; Oregon; Arizona; and Alaska—have major research programs addressing substance abuse in Native American populations. There has been little coordinated effort however.

To address this situation, SAMHSA is sponsoring the Native American National Substance Abuse Center mentioned above to help act as a clearing house for research and to help coordinate some of these efforts.

In April, 2003, the National Institute of Mental Health (NIMH) convened a major conference in the Four Corners area of the Southwest to seek input from Indian Country about methods and approaches to more appropriately conduct and interpret research among Native Americans and Alaskan Natives.

IHS is sponsoring a consortium of tribally enrolled Native American researchers to create a national research agenda and approaches specific to Native Americans. This is the first time exclusively Native American researchers have been brought together to develop means and methods to address Indian specific research. They are promoting the new concept of "Convergent Research" which refers to the convergent areas of western based scientific methods and Native American traditions. Frequently these two divergent areas collide in research approaches, with the Native people being studied often victimized by the approach, ie, seen as a means for publishing potential; financial gain; or simply as "subjects" not people. The adverse effects of these have been profound for Native Americans and they remain, as a group, very skeptical of western research as a result. The Native researchers in the consortium seek to find the common ground among these divergent approaches (Native and Western) and use it as a basis for long term research and scientific discovery. The first national meeting of the consortium is September, 2003.

Finally, data have been difficult to gather and the systems for gathering them have not been available. IHS funded software development is now being deployed nationally, free of charge, to all Native American tribes and programs that receive IHS services or contracts. The benefit for programs is they get a comprehensive assessment, treatment, and trending package that can be used for everything from an electronic patient chart to statistical trending tool—all at no cost to the program except the hardware necessary to run it. IHS, in turn, will have these same data reported to the IHS national database and be available to perform robust statistical analyses on Native American populations locally to nationally, including causality/correlates; assessment and treatment effectiveness.

Question from Representative Faleomavaega
For the Administration:

1. **Does the administration have an estimate of how much they think the health care bill should cost in order to provide the needed health care to the Native American community?**

ANSWER:

The Indian Health Care Improvement Act Reauthorization was introduced by Senators Campbell, Inouye and McCain. The Congressional Budget Office provided cost estimates for S.212 only on those provisions impacting Medicare, Medicare, SCHIP and other spending provisions. This estimate projected total mandatory cost of S.212 to be $6.818 billion between 2002-2011.

The President's request for FY'04, based on current program authority , was for $3.6 billion, the largest request in IHS program history. IHS, however, has estimated in its health disparity index, that Indians who receive services through the IHS are funded at about 52 percent of the benefits received by participants in the Federal Employees Health Benefits (FEHB) program. This report suggests that current programs funding might need to be increased about 48 percent to reach a level of benefits provided to individuals in the FEHB program. No current proposals, however, including S.556, request such an increase.

Joint Committee Hearing on the Indian Health Care Improvement Act Reauthorization
Submitted Questions

From Rep. Don Young to Dr. Grim:

1. **In H.R. 2691, the House Interior Appropriations bill, the Committee included language which states that IHS sanitation funds should not be used to provide sanitation facilities for new homes funded by the housing program of the Department of Housing and Urban Development. Do you agree with this prohibition?**

ANSWER:

Removing this language, by itself, would not solve the problem of providing sanitation facilities and other infrastructure needs to new homes funded by HUD. Under the current authorizations the IHS does not currently have sufficient funds or staff to serve the new non-HUD homes and existing homes. In Fiscal Year 2002, 349 new non-HUD homes were not reached by IHS with available funding. In addition, there is a total backlog of $1.6 billion in needs to serve existing homes. If the language was removed and additional funds were identified to provide sanitation facilities for new HUD-funded homes, there is currently no reliable source of data on HUD housing project starts to allow IHS to accurately prioritize needs and distribute the funds to address the need.

Do you believe this defeats the purpose of raising the physical, mental, social and spiritual health of American Indians and Alaska Natives by prohibiting the use of IHS funds to provide adequate sanitation facilities to help prevent infectious diseases?

ANSWER:

IHS does have an interest in ensuring that all American Indians and Alaska Natives live in safe and healthy homes. However, IHS is not the only source for providing funds to provide adequate water, sewer and solid waste facilities. For every dollar of IHS appropriations, another half dollar is contributed from other sources to stretch the reach of the Sanitation Facilities Construction Program. IHS continues to assist tribes in identifying non-IHS funding and providing engineering services to construct sanitation facility infrastructure for new HUD-funded homes.

2. **What steps are you taking to resolve the backlog of sanitation facilities in Indian country?**

ANSWER:

The President's fiscal year 2004 request includes a $20 million dollar increase for IHS sanitation facilities to help address the backlog and need for sanitation facilities. This is an approximate 20 percent increase in funding. IHS does have an interest in ensuring that all American Indians and Alaska Natives live in safe and healthy homes. However, IHS is not the only source for providing funds to provide adequate water, sewer and solid waste facilities. For every dollar of IHS appropriations, another half dollar is contributed from other sources to stretch the reach of the Sanitation Facilities Construction Program. IHS continues to assist tribes in identifying non-IHS funding and providing engineering services to construct sanitation facility infrastructure for new HUD-funded homes.

3. **Will you be working with HHS and HUD to help eliminate this backlog with sanitation facilities in Indian country?**

ANSWER:

The IHS as an agency within HHS will continue to work with the Department and through multiple agencies outside the Department including HUD, USDA, EPA and BIA to help eliminate this backlog of needed sanitation facilities in Indian country.

From Chairman Pombo to Dr. Grim:

1. **How do you propose to work with HUD and tribes to resolve the sanitation backlog in Indian country?**

ANSWER:

The IHS plans to continue to update and maintain the Sanitation Deficiency System (SDS) in consultation with tribes, so that tribes and agencies understand what needs exist. This system has been very successful in facilitating non-IHS funding. In addition, the IHS will continue to participate in the Interagency Infrastructure Task Force to foster coordination of agencies in the delivery of infrastructure services. In a recent meeting, the Infrastructure task force started discussing the development of a housing data system to track HUD housing Construction in Indian country to allow for identification of infrastructure needs. The IHS is developing training, scheduled for early 2004, to help IHS and tribal engineers and planners to access new funding sources. We will continue to work with tribal groups and the Interagency Infrastructure Taskforce to communicate the need for infrastructure considerations in community development.

Joint Committee Hearing on the Indian Health Care Improvement Act Reauthorization
Submitted Questions

Questions from Ranking Member Rahall
For Dr. Grim:

1. **Dr. Grim, you state in your written testimony that the health bills before the two Committees continue to neglect those issues which are of concern to the Administration, such as costs, etc. However, it was the testimony of Ms. Joseph that through the consultation process, which included the IHS, concerns of the Administration had been addressed.**

   Is it your testimony that the consultation was not exhaustive, as it did not fully address the concerns of the Administration? Was there a point in time where you think the consultation process failed?

   ANSWER:

   In 1999, in anticipation of the reauthorization of the Indian Health Care Improvement Act (IHCIA), the IHS undertook a series of area and regional consultation with Tribal and urban Indian health program leaders on amendments or changes that should be considered during the reauthorization of the IHCIA, which was due to expire at the end of fiscal year 2000. The IHS did not imposed limitations or parameters such as costs or program expansion to be considered during the consultation process. Since the statute was first authorized in 1976 and amended over the years, the health care environment of the entire country was changing in many ways, including and moving more towards outpatient, community-based, and managed care. IHS wanted to learn the impact of these changes on the ability of tribal governments and urban Indian health programs to successfully administer health programs for the benefit of their citizens and beneficiaries.

   Throughout the consultation process, the IHS reminded the attendees to the consultation meetings that while they were advising the agency of changes and amendments that were necessary or desired, the final recommendations developed through this process were not to be construed as having the support of the IHS, the Department or the Administration. We were clear about the formal legislative review process that any legislative proposal must undergo before final support from the Administration. Tribes and urban program leaders understood this process.

   After almost a year of consultation, the tribal and urban Indian health leadership decided that they would draft their own reauthorization bill. In October, 1999, the National Steering Committee on the reauthorization of the IHCA finalized a bill

that was forwarded to the Congressional Leadership, the President, the Department and the IHS urging all parties to support the tribal bill.

In the fall of 1999, the reauthorization bill was introduced in the House based on the tribal draft developed as a result of the consultation and Steering Committee processes. The Senate introduced an identical bill in the spring of 2000. I believe the consultations were a successful and useful part of the process. They provided opportunities for Tribal and urban health program leaders throughout the country to come together and share common health care issues. In fact, the bill that was developed by Tribal and urban Indian health care leaders is considered a "consensus" bill that includes cross cutting health proposals. IHS program officials had the opportunity to hear the issues and concerns raised by Tribal governments and health care providers.

The consultation with tribes and urban health program leaders was not intended to conclude with a legislative proposal that would be automatically be endorsed by the Administration, but rather to serve as a starting point for examining proposals that should be considered during the reauthorization effort. Since the bills introduction, there have been congressional hearings on the bills and these bills have evolved based on input from Tribal and urban Indian health leaders, as well as national Indian organizations and the Administration.

2. **You also testified that it was a concern of the Administration that continued consultation with the tribes would be too costly and be too much of a burden on the Administration.**

Do you have any recommendations on how to minimize this burden and cost, but still uphold this consultation process that the tribes and the National Steering Committee found to be highly effective?

ANSWER:

The National Steering Committee (NSC) which was established during the consultation in 1999 is comprised of a tribal representative from each of the 12 IHS areas of Indian country. In addition to these 12 members, there is a representative from the Self-Governance Tribes, a representative from the National Council of Urban Indian Health, and the National Indian Health Board. The NSC acts as the focal point for monitoring the progress of the reauthorization legislation, but also communicates with IHS as to their views on the bills as they move through the legislative process. The NSC has acted as a "voice" for Indian country on the reauthorization of the IHCIA. The NSC is a mechanism for continuing the communication with Indian country on the reauthorization effort.

In addition, IHS utilizes national Indian organization meetings, as well as regional Tribal and urban Indian health conferences as venues to continue discussions on

the reauthorization. DHHS and component agency consultations with Tribes also provide opportunities for discussion of the IHCIA reauthorization as well as other issues of concern to Tribes.

3. **How would you address the fact that tribal consultation in such important matters such as these, is necessary to continue the government to government relationship between the Federal government and Indian tribes?**

ANSWER:

The Department and the Indian Health Service understands the importance of consultation in upholding the government to government relationship between tribe and the Federal government. We are committed to consultation as reflected in the consultation policy of the Department, and this Administration. As an example, the Department consults with Tribes and urban Indian health leaders as we develop the annual budget for the Indian Health Service. Tribal input is key to the development of sound federal budget and policy decisions that affect Indian people.

The Secretary and Deputy Secretary implemented the practice in 2003 of conducting annual field-based tribal and Tribal organization consultation sessions in each of the HHS regions. The 2003 session concluded on August 15, and each Tribe was invited to participate in one or more of these sessions. Tribal representatives were also provided the opportunity to submit additional comments during their review of the draft proceedings of these sessions. At every session Tribes indicated the importance and priority for reauthorization of the Indian Health Care Improvement Act. These sessions also included the opportunity for Tribes and Tribal organizations to make recommendations to the Department on revisions to current HHS Consultation Policy.

Written Testimony of the Walker River Paiute Tribe
Regarding the Reauthorization of the
Indian Health Care Improvement Act

Before the Joint Hearing of the
United States Senate Committee on Indian Affairs
And the
United States House Resources Committee

Submitted by
The Honorable Victoria Guzman

July 8, 2003

Introduction

On behalf of the Walker River Paiute Tribe, I would like to thank the Chairmen and other distinguished members of the Senate Committee on Indian Affairs and the House Committee on Resources for the opportunity to submit written testimony on the re-authorization of the *Indian Health Care Improvement Act* and related health care issues of the Walker River Paiute Tribe.

The Walker River Paiute Tribe supports S. 556, the *Indian Health Care Improvement Act Reauthorization of 2003,* and its core principles of improving the health of Indian people, delivering federal health services consistent with the federal-tribal government-to-government relationship, and maximizing tribal participation in the planning and management of health services.

The Walker River Paiute Tribe is a federally recognized Indian tribe organized under the *Indian Reorganization Act of 1934.* Our reservation was established by Executive Order in 1889 and is located 100 miles southeast of Reno, Nevada. We have approximately 2,800 enrolled tribal members. The Walker River health facility, built in 1930, houses the Tribal Health Clinic and the Indian Health Service (IHS) Schurz Service Unit. Besides providing health care for over 1,300 tribal members, the health facility serves more than 13,000 Indian people in all of western Nevada. The health clinic also serves as the first emergency and medical response facility along the 75 mile corridor of Highway 95 between Fallon and Hawthorne, and Highway 95-A between Schurz and Yerington. Additionally, the IHS Schurz Service Unit processes approximately 15,000 contract health service claims per year.

We applaud the efforts of the Committee to ensure that the reauthorization of the *Indian Health Care Improvement Act* addresses Indian health care needs. While the efforts of this Committee, tribal nations, IHS, and Indian health care organizations have accomplished much in the years since the current

reauthorization process began, there is much more that still needs to be done to improve the health of Indian people.

The main focus of my testimony will be on Title III, Facilities. I will also address other sections of the *Indian Health Care Improvement Act* that are important to the Walker River Paiute Tribe.

Title III - Facilities

The purpose of Title III is to provide construction and renovation of health facilities.

Currently, there are over 500 facilities that provide health care to Indian people. Many of these facilities are old and need major repairs and maintenance. Some facilities need to be replaced entirely. The unmet facility and construction cost for IHS is nearly $500 million. With the current rate of congressional funding, it will take more than 70 years to complete all construction projects on the IHS priority list.

As a result of limited funding, the *Indian Health Care Reauthorization Act* establishes a priority system in which the highest priority will be based on the needs of tribes. The Walker River Paiute Tribe was once on the IHS priority list for the replacement of our health facility, but in 1990 we were removed from the priority list. To this day, we have never been given a full answer from the IHS for the reason Walker River was removed from the priority list.

The existing Walker River Tribal Health Clinic was built in 1930, and has been the subject of many federal studies. The Federal Emergency Management Agency (FEMA), the Bureau of Reclamation (BoR), and the IHS have all determined that our health facility poses dangerous, and even life-threatening hazards to employees and to patients.

In 1994, President Clinton ordered FEMA to coordinate and conduct seismic evaluations on all federal buildings. The BoR conducted the evaluation of the Walker River Health Clinic. The joint FEMA/BoR report concluded that "the building should be either permanently evacuated, the building occupancy modified (i.e. storage), or the building should be demolished and re-constructed." The report further emphasized that because of the life-threatening and hazardous conditions to which patients and employees are exposed, the building is not suitable for human occupancy.

The IHS has also studied the facility and reported that in addition to the high seismic risk, the facility has serious environmental deficiencies. Given the fact that this facility is a health clinic servicing over 15,000 Indian people a year, this finding is especially troubling. IHS also found potential problems with the soils located under the building. IHS found that even if the building were retrofitted, the underlying soil would cause non-uniform settlement, and noted no economical method of stabilizing these potentially liquefiable soils.

Furthermore, the Bureau of Indian Affairs (BIA) recently completed an analysis on the Weber Reservoir, located north of the Walker River Indian Reservation. The BIA study determined that the Walker River Health Clinic is located on a flood plain. Additionally, an investigation of a 1994 explosion at one of the maintenance buildings revealed broken gas lines resulting in diesel leakage and contamination of the ground water system located at the Walker River Health Clinic.

FEMA, IHS, and BoR have all found that the continued operation of the Walker River Health Clinic poses dangerous, life-threatening hazards to the employees and patients. They have also found that retrofitting the building, which is more than 70 years old, is not a feasible solution. Total replacement is our only available option. The federal agencies that conducted studies on the our health facility have concluded that the Walker River Health Clinic must be replaced.

While we understand that IHS has always been under funded, and that it will take more than 70 years to complete construction of facilities on the present priority list, we support new financing options in Title III that would give IHS the financial flexibility to pursue other sources of funding to address the massive need for health care facility construction.

One such financial program is the Joint Venture Construction Cost Program (JVCP) within Title III, Section 312. The JVCP uses an innovative financing process in which tribes secure a tribally owned health care facility and enters into a ten year no-cost lease with the IHS. In return the IHS provides staffing, equipment, and administrative operation of the health care facility for the duration of the lease.

Again, we support financing measures that will assist tribes to acquire and maintain health care facilities.

Title I – Indian Health, Human Resources and Development:

We support the purpose of Title I, which is to increase the number of Indian people entering health professions and to provide a greater supply of health professionals to IHS, Indian tribes, and tribal health organizations to address the shortage of Indian health professionals. Indian health care has chronically been understaffed and under funded, as a result Indian Country has fewer health professionals than our population demands. Additionally, because the majority of IHS and tribal health care facilities are located in rural areas, recruiting and retaining health professionals is increasingly difficult.

The Walker River health facility is currently experiencing shortages of health professionals. Our health facility had been without a Registered Nurse (RN) all of last year. We recently were able to hire an RN only to lose our Licensed

Practical Nurse (LPN). We have been searching for a replacement LPN for eight months and will most likely be searching for months to come. Additionally, our Dental Officer left because of the rural location and isolation of our health facility. Currently, a Dental Officer from Pyramid, Nevada makes a one-thousand mile round trip stop at our health clinic once a week. The shortage of health professionals on our reservation negatively impacts the quality of health care that tribal members receive.

Title II – Health Services

The purpose of Title II is to meet the health care needs of Indian people in an efficient and equitable manner and to eliminate deficiencies and disparities in health care funding and services. Far too many Indian people continue to die before the age of 40. Diabetes, heart disease, cancer, high cholesterol, chronic liver disease, severe obesity, smoking and inactivity are all the health problems Indian people suffer at rates higher than the general population. Title II serves to blend Western medicine with traditional knowledge to provide effective health care delivery to tribal members.

We specifically support Section 204, Diabetes Prevention, Treatment, and Control. Today, diabetes in Indian communities is reaching epidemic proportions. A recent IHS report revealed that diabetes in Indian People is four to eight times more common than the general population in the United States.

The Walker River Paiute people, as the statistics bear painful witness, are no strangers to diabetes. However, our tribal members with diabetes must endure an additional hardship and indignity of having to travel hundreds of miles three times a week for up to two years – the average duration for people receiving dialysis treatment, to receive health care. The trip is particularly hard for the elderly. Sadly enough, one of our tribal members, Carl Sam, refused to seek dialysis treatment – or rather, did not want to go through the harshness of the long trips on top of the ordeal of dialysis treatment. Needless to say, the lack of a dialysis unit at the Walker River health facility contributed to his death.

In addition to meeting the needs of Indian people in all of western Nevada, the Schurz service unit has the potential to meet the health care needs of non-Indian people living in the remote areas of western Nevada. Non-Indian diabetics are also in desperate need of a local dialysis treatment center which we are proposing for the Schurz Service Unit.

These statistics and stories of loss and hardship make passing the reauthorization of the *Indian Health Care Improvement Act* and its provisions important.

In addition to Section 204, the Walker River Paiute Tribe supports Section 209. Currently, there is no epidemiology center at the Schurz Service Unit. It is

extremely important an epidemiology center exist to assist the Tribe with developing health service priorities, and incidence and prevalence rates of disease and other illnesses in our reservation and service area. For decades the United States Navy has used land near our reservation – and on many occasions our own land- as a bombing range and training area. Unexploded ordinance, explosives and related chemicals have impacted our environment. Unfortunately, without an epidemiology center to evaluate and compile data, the health impacts of the bombing range will remain unknown.

Title IV- Access to Health Services

Though many Indian people are eligible to participate in Medicaid and Medicare, there are many barriers which limit their participation. Title IV attempts to eliminate those barriers by:

- maximizing recovery from all third-party sources, including Medicaid, Medicare, and any federally funded health care programs.
- by ensuring that Indian people have access to health care provided by tribes and tribal health care organizations.
- by ensuring that the full cost of providing health care services are reimbursed to a tribal health care provider.

Currently, tribal and IHS per-capita health expenditures do not have the parity of per-capita expenditures of other federal health care programs. The December 1999 Level Need of Funding Study (LNF) revealed that funding for Indian health was only 60 percent ($1,495 per-capita) of the comparable services for federal employees ($2,980 per-capita). This disparity is made more evident in comparison to expenditures for Medicare beneficiaries ($5,800 per-capita), Medicaid beneficiaries ($3,600 per-capita), and Veterans Administration beneficiaries ($5,458 per-capita).

At the same time, new Medicaid managed care efforts are largely controlled by State governments and managed care providers who do not make reasonable reimbursements to Indian health programs.

While improvements have been made to increase reimbursement rates within Indian health programs, the net gains in collections simply do not equal the disparity inherent in the IHS Budget. As a result, Indian people in the IHS programs are being served at one-third the level available to non-Indian Medicaid beneficiaries, only one-fifth the level available to Veteran's Administration beneficiaries, and at unequal levels of funding within the IHS tribal system. This is an issue of basic fairness and equity.

Efforts to enhance collections from third party sources enables Tribal and IHS health programs to provide better health services to Indian people. The Walker River Paiute Tribe supports removing limitations that hinder access to

Medicaid and Medicare and Child Health Insurance Programs so that Indian health programs can take maximum advantage of these funding sources.

Title V – Health Services for Urban Indians

Title V authorizes health outreach, referral, and the delivery of services to Indian people in urban areas in a broad array of health care components. Currently, urban Indian health programs serve approximately 149,000 urban Indians living in 34 cities throughout the nation. Several of our tribal members live in cities and urban areas and currently face the difficulties of acquiring health care. The Walker River Paiute Tribe supports the legislative language in Title V.

Title VI – Organizational Improvements

We support the establishment of the IHS as an agency of the Public Health Service (PHS). We feel that IHS will more effectively and efficiently carry out its mission to provide quality health care to Indian people as a service within the PHS.

We support the elevation of the Director of IHS to Assistant Secretary of the IHS in the hope that this elevation would provide more standing for the IHS to advocate more effectively for the many needs of Indian health care and to improve government-to-government consultation on important health issues impacting Indian people.

Furthermore, though we support Section 602, the Automated Management Information System, we must caution that funding for this Section should not be diverted from health care programs in Indian Country. Indian health care is desperately under-funded as it is. An added expense would further cut into the efforts to improve health care for Indian people.

Title VII – Behavioral Health

We support Title VII's purpose to develop comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. Today, Indian people are dealing with high rates of alcoholism, depression, substance abuse, and domestic violence. We need a comprehensive and culturally holistic approach to deal with wide-spread behavioral health problems on our reservation.

Comments on the One-HHS Initiative

Tribal consultation is an important issue in the reauthorization process. During the last Committee hearing on the reauthorization of the *Indian Health Care Improvement Act*, Senator Campbell expressed concern on tribal consultation within the Department of Health and Human Services' (DHHS) "One-HHS" initiative. While we support Secretary Thompson's commitment to improving health services and creating Departmental efficiency, we are

concerned with the potential tribal impacts from Secretary Thompson's Departmental consolidation.

Furthermore, the Senate Committee on Appropriations did not agree with consolidating certain IHS functions within the DHHS and expressed in its Report on the Fiscal Year 2003 Omnibus Appropriations Act that "the complexity and variety of issues that surround the provision of health services to Native Americans and Alaska Natives demand an unusual degree of expertise and experience." Indicating that the expertise and experience in working with sovereign Indian nations will be lost if important IHS functions are subsumed by DHHS.

One such consolidation effort is centralizing Human Resources from its twelve IHS area offices nationwide to one location in or near Washington, D.C. We feel that this will seriously hinder IHS' ability to provide direct medical care services and community-based health initiatives and its government-to-government relationship with Indian nations, which furthers tribal self-determination and self-government.

Additionally, the consolidation of IHS' Legislative Affairs Office with that of DHHS would adversely impact the unique government-to-government relationship between Indian nations and the United States. This government-to-government relationship is, to a great extent, dependent on the interpretation and compliance of legislation that is aimed at improving the health of Indian people and strengthening tribal self-determination and self-government. By consolidating the Legislative Affairs Office, the federal government runs the risk of negating its fiduciary responsibility to Indian people. The result will be weakened ties between Indian nations, the IHS, and ultimately, the federal government.

Tribal consultation is an important element in determining the success of IHS' mission in Indian Country. Without consultation, federal agencies may make rash decisions that negatively impact the health of Indian people. This, simply, is too high of a price to pay to meet "cost-effective" goals of the "One-HHS" initiative.

Conclusion

The federal trust obligation to provide health services to American Indians and Alaska Natives has grown out of a unique relationship between tribal governments and the United States. This government-to-government relationship arises from Article 1, Section 8, Clause 3 of the United States Constitution, that recognizes the specific authority for federal jurisdiction over Indian affairs. Over the course of 215 years, this unique federal and tribal relationship has been underscored by Treaties, Statutes, Executive Orders, and decisions of the United States Supreme Court.

In many of these treaties and executive orders between Tribes and the federal government, specific provisions for basic health care, such as the construction and maintenance of hospitals and the services of a physician were included.

In 1976, when Congress enacted the *Indian Health Care Improvement Act,* it favorably and forever changed the face of Indian health policy. The Act is one of the most comprehensive efforts by Congress to address the health needs of American Indian and Alaska Native populations. The Act's intent is to address:

- long-standing deficiencies in Indian health care
- to increase the number of health professionals serving Indian Communities
- to rectify health facility problems
- to authorize services to urban Indian populations
- to provide access for Indian patients to other federal health resources such as Medicaid and Medicare.

Although there have been improvements to the health of American Indian and Alaska Natives since the *Indian Health Care Improvement Act* was enactment 27 years ago, Indian health and health care is still far behind all other groups in the United States. Most importantly, Indian health care has consistently been under-funded since its creation. While funding for the fight against diabetes has been substantially increased, funding for many other areas of Indian health also needs to be substantially increased to bring health care for Indian people up to par with the health care for the general population of American citizens.

Regardless, the reauthorization of the *Indian Health Care Improvement Act* certainly inspires hope in many Indian nations that long standing and often neglected health issues will begin to be successfully addressed. The day of receiving quality health care that is equal -if not better than the general population of the United States- is closer to becoming a reality, thanks to the Committees' diligent work, as well as the work of many tribal nations, organizations, and the IHS.

On ending, the Walker River Paiute Tribe and myself thank you for the opportunity to submit written testimony to the Senate Committee on Indian Affairs. We would also like to extend an invitation for you to visit us at the Walker River Paiute Reservation. If there are any questions please contact me at (775) 773-2306, or our tribal health director Mr. Ken Richardson at (775) 773-2005, or you may can contact Daryl Begay at (202) 457-2557.

TESTIMONY OF RACHEL A. JOSEPH
Co-Chair of the
NATIONAL STEERING COMMITTEE ON THE
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Before the United States
Senate Committee on Indian Affairs
and
House Committee on Resources
July 16, 2003

Good morning, Chairman Campbell, Chairman Pombo and members of the Committees. My name is Rachel A. Joseph Chairperson of the Lone Pine Paiute-Shoshone Tribe and Co-Chair of the National Steering Committee (NSC) on the Reauthorization of the Indian Health Care Improvement Act (IHCIA). I also serve as Chairperson of the Toiyabe Indian Health Project, Inc. which is a consortium of nine Tribes serving Inyo and Mono counties on the eastern side of the beautiful Sierra Nevada mountains in Central California. I am here today on behalf of the National Steering Committee to testify in support of the reauthorization of the Indian Health Care Improvement Act. The draft bill which we presented to these committee was the most comprehensive since the IHCIA was first enacted in 1976; and, we believe that draft was consistent with our Nation's policies and priorities. Further, it contained recommendations for changes that are necessary to improve the ability of Tribal health programs, urban health programs, and the Indian Health Services (I.H.S.) to provide comprehensive personal and public health services that are accessible to American Indian and Alaska Native people.

I. BACKGROUND

The I.H.S., an agency in the Department of Health and Human Services, was founded in 1955. Prior to 1955, health services for Indian Tribes in the United States were provided by the Bureau of Indian Affairs in the Department of the Interior, which was established in 1849. Some treaties with Indian Tribes provided specifically for health services and before 1849, the War Department and philanthropic organizations provided some health care to tribes. The Congress intermittently appropriated funds for Indian health after 1832; and, by 1880 four hospitals for Indians were operated by the Bureau. In 1908, for the first time, the BIA health program was placed under the direction of a health care professional. Until 1921, BIA health services were funded by Congress without any authorizing legislation.

Although Congress expressly authorized the Bureau to expand federal appropriations for the conservation of health in 1921(Snyder Act); but very little progress was made in addressing Indian health needs from 1921 until 1955. By that time, the poor BIA record for the administration of health care services led to a demand for a transfer of Indian health programs to the Public Health Services in the Department of Health, Education and Welfare.

On August 17, 1954, Congress enacted the Transfer Act which transferred "all functions, responsibilities, authorities, and duties of the Department of the Interior...relating to the maintenance and operation of hospital and health facilities for Indians and the conservation of the health of Indians" to the United States Public Health Service. Since the implementation of the Transfer Act in 1955, the Indian Health Service, as part of the U.S. Public Health Service, has achieved significant improvement in the health status of Indians and Alaska Natives. Also since 1955, the Indian Health Service has grown in budget and staffing which enabled it to be more responsive to the health needs of Indians. According to I.H.S. figures, between 1955 and the late 1970's, the three-year average infant mortality rate for Indians was reduced by 74 percent, maternal mortality was reduced by 90 percent, and Indian deaths per thousands from tuberculosis dropped by approximately ninety-one percent.

In 1976, Congress found that "the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States." Rates of death from tuberculosis, influenza, cirrhosis, and infant death remained well above the national average. The failure of the Indian Health Service to involve Indians in planning and delivering health services was also severely criticized.

Consequently, Congress enacted the Indian Health Care Improvement Act, "to implement the federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes". The IHCIA has been the cornerstone for Indian health services since its enactment in 1976. The Act has been reauthorized four times, most recently in 1992.

The reauthorization of the IHCIA represents an opportunity to address changes in the health care environment and the impact of these changes on the needs of the I.H.S./Tribal/Urban (I/T/U) health care delivery systems:

> "A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and delivery of health services." (P.L. 94-437)

As amended in 1998, the Indian Health Care Improvement Act provides detailed directions to the I.H.S. concerning Indian Health manpower, equity in funding Indian health services, alcoholism programs, programs for urban Indians and many other health-related matters. Achievements under the Indian Health Care Improvement Act have been limited by inadequate funding. Nevertheless, the 1976 legislation provided

the first detailed statutory guidance to the Indian Health Service as to particular services and programs which Indians and Alaska Natives are entitled to receive.

Federal health services to Indians and Alaska Natives has resulted in a reduction in the prevalence and incidence of some illnesses and unnecessary and premature deaths.

Despite such services, the unmet health needs of the American Indian people today remain alarmingly severe and even continue to decline. The health status of Indians is far below the Health status of the general population of the United States. The disparity to be addressed is formidable. Oral health conditions of our population is poor with our patients experiencing approximately 3 times that amount of tooth decay and periodontal disease that the US general population.

The mortality rate for Indian people due to diabetes is 420% of the rate for the rest of the nation. The occurrence of Type 2 diabetes is rising faster among our children and young adults than in any other population; and, its occurrence is 2.6 times the national average. The number of American Indians and Alaska Natives suffering due to end stage renal disease is 2.8 times the rate for white people; and, the rate of diabetic end stage renal disease is 6 times the rate for the rest of the nation. Amputations due to diabetes occur at rates 3 to 4 times the rates for the rest of the nation. Cardiovascular disease is now the leading cause of mortality among Indian people, with a rate that is almost 2 times that of the U.S. general population. The death rate for Indian people, due to accidents, is 280% of the rate for the U.S. general population; and, for alcoholism the rate is at 770%. Our pneumonia and influenza death rate is 52% greater and the tuberculosis death rate is 650% greater. The recent fully analyzed and racially adjusted mortality data (FY 1999) available from the National Center for Health Services documents an overall 4.5% increase rate for American Indian and Alaska Native people from 698.4 per 100,000 population for the period 1994-1196 to 730.1 per 100,000 for the period 1997-1999.

II. CONSULTATION PROCESS

In 1999, for almost ten months, tribes engaged in a tribally-driven consultation process with the Indian Health Service (I.H.S.) and urban Indian health providers regarding the reauthorization of the Indian Health Care Improvement Act. This process began with the first Area consultation meeting in San Diego, December 1998, with over 100 participants who gathered to develop California Area recommendations for the reauthorization. Subsequent to the San Diego meeting, each Area of the I.H.S. convened meetings of Tribal leaders and urban providers to discuss the reauthorization of this important legislation. Discussions were held over the course of several meetings with the expectation that Area concerns and recommendations would be forwarded to the next step in the consultation process. It was agreed, that the goal of the process

was to build a consensus on the issues before us and that the draft legislation which was to be submitted to Congress, would reflect a consensus of the Indian Health Service/ Tribes/Urban Programs (I/T/U), to ensure that when we spoke of the reauthorization we would be **"Speaking with One Voice".**

Regional Consultation:

From January through April, 1999, four regional meetings were held across the United States. These regional meetings were intended to provide a forum for I/T/Us to provide input, to share the recommendations from each Area, and to build consensus among the participants for a unified position from each region and throughout Indian Country.

National Steering Committee:

Upon completion of the four regional meetings, the I.H.S. Director convened a National Steering Committee to develop a report on national policy issues and IHCIA recommendations. The National Steering Committee is composed of one elected tribal representative and one alternate from each of the twelve Areas, a representative from the National Indian Health Board, National Council on Urban Indian Health and the Tribal Self-Governance Advisory Committee.

A 135-page matrix, comparing the recommendations from each of the four regions for every section of the IHCIA, was reviewed by the National Steering Committee to develop a final consensus document. The work was divided into five teams as follows:

(1) Health Services Workgroup for Titles I, II, V, and VII, Chaired by Dr. Taylor McKenzie;
(2) Health Facilities Workgroup for Title III, Chaired by Julia Davis Wheeler and Robert Nakai;
(3) Health Financing Workgroup for Title IV, Chaired by Buford Rolin;
(4) Miscellaneous Workgroup for Titles VI and VIII, Chaired by Tony Largo; and,
(5) Preamble Workgroup, Chaired by Henry Cagey.

Each group had primary responsibility for final presentation of recommendations setting forth a framework for reauthorization legislation to the full NSC.

It was a consensus of the NSC that specific "draft bill language" would be developed and proposed by the National Steering Committee to minimize any misinterpretation of our position. The NSC maintained an aggressive schedule of meetings as follows:

Rockville, MD	June 3, 4, 1999
Gaithersburg, MD	June 17, 18, 1999

Rockville, MD	July 7, 8, 9, 1999
Reno, NV	July 13, 14, 1999
Washington, DC	July 27, 28, 29, 1999 (National Meeting)
Salt Lake City, UT	August 30, September 1,2, 1999
Rockville, MD	September 28, 29, 1999
Palm Springs, CA	October 5, 1999

The National Steering Committee discussed many of the important issues in the full group and others were delegated to individual workgroups. Some of the major issues requiring much discussion by the full group included:

1. **Entitlement:** Whether to seek legislative changes to create an Indian health care entitlement was discussed. The issues were referred to a special committee who did research and provided an overview of the pros and cons of making the delivery of Indian health care an entitlement. It was a consensus that a commission be established to further study and develop recommendations. A key issue is the definition of what an entitlement would be for Indian health care.

2. **Urban Programs:** There was much discussion on how urban health programs should be included in the IHCIA. It was agreed by the full NSC that urban health issues should be addressed fully in Title V and in certain areas in other titles as appropriate (research and certain financial authorization) where it would be unnecessarily cumbersome to duplicate language in Title V.

3. **Permanent or Term Legislation:** There was considerable discussion about whether to seek permanent legislation or term reauthorization. It was agreed that Congress and Indian Country should revisit Indian health care periodically. We propose a term of 12 years for this reauthorization.

4. **Follow-up:** The NSC discussed and agreed to form a special initiative to work on the passage of reauthorization legislation. The National Steering Committee continues to function as the link between grass roots concerns and the reauthorization process. A special committee comprised of the two NSC Co-Chairs, Chairs of the NSC work groups and representatives of the National Indian organizations was established to coordinate efforts related to the passage of the reauthorization legislation.

5. **Tribal-Specific Proposals:** The steering Committee agreed that Tribal specific proposals in the Steering Committee bill would not be included unless the following criteria was met:

- The provision had national significance with potential for benefit and replication nationwide; and, current federal law does not authorize or prohibits implementation or funding;

- The provision will not adversely affect or diminish funding which is available to other Indian programs or the I/T/U system that it has a right to; and,

- The provision was reviewed and endorsed at the Area, Regional and National IHCIA consultation levels.

The NSC also recognizes that Congress and tribes will work through the legislative process and that the final law may contain tribal-specific proposals.

National Forum:

At the conclusion of all four regional meetings and after the NSC had met four times to develop draft consensus bill language, a national meeting, co-sponsored by the Senate Indian Affairs Committee was held here in Washington D.C. This meeting was to provide additional opportunity for Tribal leaders, urban health representatives, national organizations, federal agencies, and friends of Indian health, to provide "feedback" on the legislative proposal. Before the July 16, 1999 meeting, the draft bill language was mailed to over 1200 tribal leaders, tribal health directors, I.H.S. officials, and urban health programs and other health organizations.

The Steering Committee addressed all of the approximately 1000 comments received; and, incorporated many comments and recommendations into the proposed bill to reauthorize the Indian Health Care Improvement Act. A copy of the draft bill was delivered on October 8, 1999 to both the Senate Indian Affairs Committee and the House Committee on Resources and other appropriate committees with jurisdiction. A copy of our proposed bill was mailed to every tribe and Indian organization.

III. KEY PROVISIONS

S.556 and H.R. 2240 reflects the NSC recommendations which were based on all the input and recommendations we received and addresses the following major issues:

Preamble

The Preamble Section of the Act, as revised by the NSC, includes sections on Findings, Declaration of National Policy, and Definitions. Emphasis is placed on the trust responsibility of the Federal government to provide health services and the entitlement

of Indian tribes to these services. The "Declaration of Health Objectives" has changed to "Declaration of National Policy". The NSC proposed and S.556 and HR 2240 eliminates the enumeration of 61 distinct objectives and provides that the Federal government will raise the health status of Indians to the levels set forth in "Healthy People 2010" or successor standards. The new Preamble underscores consultation with Indian people and the importance of the Federal-Tribal relationship. Numerous additions to the Definitions Section were made to conform to changes in later titles. When definitions applied only to one section of the Act, the definition is provided in that section and not in the Definitions Section.

Local Control (Self-Determination)

Some programs which have been administered by I.H.S. headquarters were decentralized, with funds distributed to I.H.S. Area Offices for local priority-setting and decision-making by tribes, and includes decisions about whether further distributions should be made available to individual tribes or service units. This feature has been incorporated in Title I programs for recruitment and training of health professionals.

Entitlement

The NSC heard from many tribal leaders supporting authorizing Indian health care as an "entitlement" program. Currently, funding for Indian health is considered a "discretionary" program in the federal budget.

NSC Members and tribal leaders considered the critical issue such as what would entitlement mean for Indian health care: (1) how to effectively set out the basis for an entitlement from a political perspective; (2) how to address the anticipated increased cost of an entitlement program; (3) how an entitlement provision would effect the overall bill; and, (4) how an entitlement program would be designed.

While the NSC agrees that the Federal government has a trust responsibility to provide Indian health services and facilities, it recognizes that there are may unanswered questions regarding what constitutes an entitlement; what criteria should be applied to define the entitlement class; whether the entitlement flows to tribes or individual Indian people; and, what benefits should be included in an entitlement package.

At the recommendation of its Entitlement Subcommittee, the NSC included in Title VIII of the draft bill, a provision that would create a Tribal/Congressional Commission to evaluate entitlement issues and make recommendations to Congress on how Indian health care can be provided on an entitlement basis. The NSC considers this provision to be a starting point and welcomes further comments.

Qualified Indian Health Program (QIHP)

The proposal created a QIHP as a new "provider type" for Medicaid and Medicare reimbursement eligibility. All I/T/Us would qualify {new Sec. 1880A of the Social Security Act}.

- There are several payment options from which a QIHP could select, including a full cost recovery method that would include indirect costs (but precluding any over recovery of indirect costs).
- A QIHP could elect to include the following services in its recovery rate: preventive primary care; SCHIP services; various immunizations; patient transportation; and, services performed by an employee licensed/certified to perform such services that would be reimbursable if performed by a physician.

In May of 2002, in a meeting at Portland, Oregon the NSC agreed that the provision authorizing this new provider type could be deleted in response to Secretary Thompson's concern that QIHP was complex and would be administratively burdensome. Also, we acknowledged that the CBO score of this provision – in excess of $3 billion over ten years – could be a deterrent to timely reauthorization of the IHCIA.

Direct Billing/Collections Demonstration

The NSC proposed making permanent and extending to all Tribal health programs the demonstration project for direct billing under Medicaid and Medicare.

Facilities

Title III regarding health facilities underwent several changes in order to provide a broad approach to address the unmet facilities needs of Indian tribes and tribal organizations; and, to develop innovative funding opportunities to meet these needs. The Title was expanded to overcome previous limitations and to give Indian tribes and tribal organizations a greater capacity to meet their various facilities needs, including the use of private sources of credit to address the health facility construction backlog. Facilities related provisions from other Titles were re-located here.

Behavioral Health Programs

Title VII in the current law is limited to substance abuse programs. In S.556 and H.R. 2440, substance abuse, mental health and social service programs are combined in a new Title VII under the heading of "Behavioral Health Programs". The objective is to integrate these services. Provisions have been added to clarify that programs are subject to contracting and compacting by tribes and tribal organizations. The term

"funding" has been used to replace "grant" in order to clarify that Tribes and tribal organizations can utilize contracts, compacts, grants, or any other funding mechanisms, and are not limited to grants.

Development of local and area-wide behavioral health plans are encouraged, and the requirement for a National Indian Mental Health Plan is dropped. The section on Youth Treatment Centers has been amended to allow at least one center per Area.

New authority is proposed for the establishment of at least one in-patient mental health care facility, or the equivalent, per I.H.S. area.

IV. SUMMARY OF TITLES

Title I – Indian Health, Human Resources, and Development

Title I was rewritten to shift some priority-setting and decision-making to the local Area levels. Throughout the Title, the listing of distinct disciplines of health professionals was eliminated and replaced with more generic terminology, which includes all health professionals, with only a few exceptions. Special programs were eliminated if these professionals disciplines were eligible to receive support under generic programs of this Title. The NSC determined that the decision for the Health Professions Scholarships should be decentralized to the Area Offices based upon Tribal consultation. The administration of scholarship funds is proposed to remain an I.H.S. headquarters function. The NSC also prefers that Title I recipients fulfill their scholarship job placement requirements in the Areas from which they received their scholarship assistance unless special circumstances require otherwise. Language was also provided to protect Title I recipients who are already in the "pipeline" for assistance. Demonstration projects are eliminated in lieu of establishing regular funding for Tribal programs across the board. A new section clarifies that all scholarships, loans, and repayment of loans are "non-taxable". Amendments in this Title clarify that tribal "matching" requirements for scholarship programs can be from any source, including other federal funds. The training and certification sections for mental health and substance abuse workers were relocated from Title II and Title VII to this Title.

Title II – Health Service

Title II represents a collection of diverse sections addressing issues related to the delivery of health services to Indian populations. This Title continues to address issues of "equity" in the allocation of health resources and attempts to address health care deficiencies. A new section provides a listing of types of services authorized, which were not previously listed. One major change in the IHCIA Title II is the removal of Section 209 "Mental Health Services" from this Title and transferring it to Title VII

"Behavioral Health". Throughout most provisions, the term "Indian Tribes and tribal organizations" has been inserted as equal partners with the I.H.S. A significant change in S.556 in Section 202, "Catastrophic Health Emergency Fund" (CHEF) is proposed. This change will authorize the I.H.S. to allocate total CHEF funds among the twelve Areas for administration at the Area level. The I.H.S. Area Offices must consult with Tribes in establishing and operating the Area CHEF program. An earlier proposal, considered by the NSC, to set a lower national threshold for Tribes or Areas "dependent" upon Contract Health Services was deleted in favor of this Area-specific approach. An Area specific allocation methodology must be negotiated with Tribes through a rule-making process. Language is included that prohibits the allocation or assignment of shares of CHEF funds under the provisions of the ISDEAA. In H.R. 2440 the CHEF provision continues to provide for the administration of chef funds as currently done.

Section 204, "Diabetes Prevention and Treatment", is expanded to establish a national program, not a "model" based program, to provide authority for the continuation of funded diabetes projects. Individually named community "models" are deleted in the bills, in favor of a national emphasis, with the intent that these programs will continue as a part of a national strategy. Several sections regarding reimbursement and managed care were shifted to Title IV.

Section 207 is expanded to focus attention on "all cancers" and not limited to, mammography screening for breast cancer.

Language is added in Section 209 to require that "Epidemiology Centers" be established in each of the twelve I.H.S. Areas. They can be contractible under the ISDEAA but not divisible.

The Comprehensive School Health Education and the Indian Youth Programs are changed to authorize funding to Tribal or urban programs throughout the United States.

The Office on Indian Women's Health Care is changed to a Women's Health Program providing funds for Tribes and tribal organizations, as opposed to an office in the I.H.S. headquarters. In addition, several sections from Title VIII are moved to Title II, including the provision on Nuclear Resource Development and Health Hazards. This Section is changed to Section 215, Environmental and Nuclear Health Hazards, and made applicable nationally to address environmental health hazards that may require ongoing monitoring or study. Section 220 provides for the fair and equitable funding of services operated by the Tribes under funding agreements just like those operated directly by I.H.S. Section 221 requires that the licensing requirements of staff employed by Tribally operated programs be consistent with I.H.S. employee requirements. All the Contract Health Service (CHS) provisions are consolidated within this Title (sections 216, 217,

218, 219, 222, 223, and 224), and strengthens the prohibition against CHS providers from holding individual Indian patients liable for CHS approved bills.

Title III – Health Facilities

Numerous changes are made in Title III to address facility concerns, Section 301 states that Tribal consultation shall be required for all facility issues not just facility closures. Recommendations on the accreditation of health care facilities are made "not to be limited only to the Joint Commission for the Accreditation of Health Care Organizations" but instead open to any nationally recognized accreditation body in S.556; and in H.R. 2440 the requirement is to meet standards recognized by the Secretary for the purposes of medicare, Medicaid and SCHIP programs under title XVIII, XIX, XXI of the Social Security Act. Annual reporting on facility requirements should not be limited to the "10 top priority projects" but reflect the true unmet need in Indian Country. A clause is included to provide protection for all projects on the existing priority list.

Language concerning Safe Water and Sanitary Waste Disposal Facilities in Section 302 of S.556, reiterates a cooperative relationship between I.H.S. and the U.S. Department of Housing and Urban Development (DHUD), regarding safe water and sanitary disposal; and, authorizes the use of I.H.S. funds to leverage additional resources. To be consistent with P.L. 86-121, the term "facilities" was used in place of "systems". After the consensus position was reached on this issue reflected in S.556 Section 302 there has been an effort by some housing advocates to amend the language that prohibits the use of I.H.S. funds for newly constructed HUD homes. Why do it since the I.H.S. Section 302 funding is already critically under funded for this "Safe Water and Sanitary Waste Disposal Facilities" program? Since 1982 Congress has repeatedly expressed its intent that none of the funds appropriated to the I.H.S. may be used for sanitation facilities for new HUD constructed homes. This system worked fairly well until 1996 when NAHASDA was enacted and funding is now distributed by a formula which does not currently account for deficiencies or cost of off-site sanitation facilities. The I.H.S. has as one of its Government Performance Results Acts (GPRA) indicators for FY 2005 to increase the proportion of American Indians and Alaska Native population receiving optimally fluoridated water by 0.5% over FY 2004 levels. The FY 2002 indicator committed to a 5% increase of American Indian and Alaska Native benefiting from fluoridated drinking water. While the FY 2002 indicator was not fully achieved, 15 small systems, not previously optimally fluoridated, became fluoridated adding 20,580 individuals to those receiving the benefits of fluoridated water. Since fluoridation is one of the most cost effective public health measures for reducing the prevalence of dental decay in all age groups we must do what we can to ensure that these limited funds remain available for these purpose. I.H.S. GPRA indicator number 35 for FY 2005 is to provide sanitation facilities to 22,300 new or like-new homes and existing Indian homes.

For FY 2004 the goal is to service 15,150 homes and in FY 2002 15,255 homes were served (2,528 new/like new and 12,727 existing).

Section 305 clarifies that Tribes, to assist in the expansion, as well as the renovation or modernization of I.H.S. or Tribal health facilities, may use any source of funds. Language in H.R. 2440 allows for peer review for small, ambulatory care facilities applications. The Indian Health Care Delivery Demonstration Project in section 306 was expanded to include facilities such as hospice care, traditional healing, childcare, and other activities. Originally, the NSC attempted to make this section more national in scope and deleted references to the nine individually named Tribal communities. However, the NSC added the list back, pending a final update or status report from the I.H.S. regarding the necessity for listing each project. If it is not necessary, the NSC supports deleting these tribal-specific references in this Title.

The bills facilitate the use of private credit sources for construction of health facilities by requiring that leases of such facilities from Tribes to the I.H.S. be treated as "operating leases" for the purpose of scoring under the Budget Enforcement Act.

A major new provision of S.556, Section 310 and Section 309 of H.R. 2440 provides for loans, loan guarantees, a revolving loan fund and a grant program for loan repayment on new health facilities. It also provides that Congress appropriates funds for a Health Care Facilities Loan Fund made available to Tribes and tribal organizations for the construction of health care facilities.

A new section is established for the I.H.S./Tribal Joint Venture Program, which was originally in Title VIII. The Joint Venture Program now appears as Section 312 of S.556 and Section 311 in H.R. 2440 and provides for creative, innovative financing by Tribes for the construction of health facilities, in exchange for the I.H.S. commitment for equipment and staffing. A new Section authorizes the use of "Maintenance and Improvement" funds to be used to replace a facility when it is not economically practical to repair the facility. Another new section, provides clarification for Tribes operating health care facilities under the ISDEAA. It states that Tribes can set their own rental rates for all occupants of Tribally operated staff living quarters and collect rents directly from Federal employee occupants. Another important new provision to Title III, provides for "Other Funding" to be used for the construction of health care facilities and opens the door for alternative financing options for Tribes and tribal organizations.

This new Section includes a provision to ensure that the use of alternative funding does not jeopardize a Tribe's placement on the priority list referred to in Section 301.

Title IV – Access to Health Service

The provisions in this Title attempt to eliminate barriers which prevent I.H.S., Tribes, tribal organizations and urban Indian health programs from fully accessing reimbursement from other federal programs, including Medicaid, Medicare, and the Children's Health Insurance Program (SCHIP), for which their patients are eligible. By eliminating barriers, it is intended that I.H.S, Tribes and urban programs take maximum advantage of these other federal funding "streams". The severe and longstanding lack of adequate appropriations for the I.H.S. requires that alternative funding "streams" be assesible to the maximum extent possible consistent with the unique Federal trust responsibility to provide health services to Indians.

The provisions in Title IV of the IHCIA, and the related conforming amendments to the Social Security Act, accomplish three major goals:

- To maximize recovery from all third-party sources, including Medicaid, Medicare, and SCHIP, and any new Federal funded health care programs;

- To ensure that Indians have access to culturally competent care provided by the Tribes, tribal organizations or urban Indian organizations, and therefore are not automatically assigned without approval to non-Indian managed care plans; and,

- To ensure that when an Indian health program provides services, the cost of providing services will be reimbursable.

In order to achieve these goals, specific amendments to the Social Security Act must be enacted. Medicaid and Medicare need to be amended to provide authorization for the I.H.S. and tribal health programs for cost recovery for all services for which these programs pay. This will eliminate out-of-date limitations to payment for services in certain facilities. The requirement that Medicaid and Medicare payments to tribal health programs be processed through the I.H.S. "special fund" has also been eliminated and I.H.S. is required to send 100% of its Medicaid and Medicare receipts to the Service Unit that generated the collection. See Sections 401, 402, and 405. To ensure accountability, S.556 Section 403 requires all Indian health programs to submit provider enrollment identification to allow the I.H.S. and the Health Care Funding Administration to track payments and reimbursements for services for the purpose of reporting and monitoring.

Several amendments are intended to improve relations between States and Indian health programs and to provide increased flexibility in these historically difficult relationships. Section 408 proposes to authorize Tribes to purchase insurance using I.H.S. funds. S.556 adds specific new language in Section 410 and HR 2440 Section

407, clarifying that I.H.S. is the "payer of last resort". S.556 Section 411 provides corollary authority which authorizes the Indian health system to bill for other federal reimbursements unless explicitly prohibited.

A new Section 412 in S.556 establishes the "Tuba City Demonstration Project" one of only two new demonstration projects recommended by the NSC. Recent changes in the Navajo Nation's administration of some of its programs caused the NSC to agree to delete this provision. S.556 Section 413 authorizes Tribes and tribal organizations to purchase Federal health and life insurance for their employees. In S.556 Section 414, specific consultation and negotiated rulemaking procedures are included to address issues with HCFA (CMS). The NSC, in response to the Administration's concerns agrees to remove this provision; and, H.R. 2440 authorizes states to consult with Tribes in Section 409.

Other amendments address related problems faced by the I.H.S. and tribal health programs in their relationship to Medicaid and Medicare and to other health providers accepting payment under contract health.

In S.556 a new provider type has been created for the I.H.S. and tribal health programs; the Qualified Indian Health Program (QIHP). It recognizes the unique cultural and programmatic characteristics of Indian health programs and provides for full cost recovery subject to efficiency measures. This section was carefully crafted to ensure that Indian health programs, to which the United States owes a specific duty, receive the benefits made available to other health providers who meet the needs of specific populations. The NSC proposed that the 100% Federal Medical Assistance Percentage will be provided to states for CHIP services reimbursed to Indian health programs, as is currently the case with Medicaid. This minimizes artificial and unfair distinctions between Indian health programs that provide direct services compared to those that must rely on contract health. A new section also authorizes the Secretary of the Department of Health and Human Services (DHHS), to contract directly with Indian Tribes through block grants for the administration of CHIP programs to Indian children within the Tribe's service area. Section of S.556 and Section 412 of H.R. 2440 will eliminate or "waive" all cost sharing for I.H.S. eligible beneficiaries served by Indian health programs under Medicaid, Medicare, and SCHIP. This section also includes language to ensure that Indian people are not subject to estate recovery proceedings or that the impact of estate recovery is minimized by eliminating trust income, subsistence or traditional income. Similarly, a new section will protect parents who are required to apply for Medicaid as a condition of receiving services for their Indian children from an I.H.S. or tribal health program or under the contract health program for their children, from being obligated to repay Medicaid under a medical child support order. Other new provisions address managed care plans. It ensures that Indian people may not be

assigned involuntarily to these plans and that such plans must pay for the services provided by Indian health programs.

In S.556 Section 424 and in H.R. 2440 Section 414 established the second demonstration program, the Navajo Nation Medicaid Agency " to serve Indian beneficiaries residing within the boundaries of the Navajo Nation, authorizing a direct relationship between the tribes and the CMS. The NSC elected to promote the Navajo Nation Medicaid agency as a demonstration effort.

The NSC recognizes that these provisions are ambitious. However, they are critical to ensuring that Indian health programs have fair access to critical Federal funding sources and the opportunity to modernize our programs to address the needs of our patients and fulfill the responsibility of the United States to Indian People.

Title V – Health Services for Urban Indians

This title covers the majority of provisions for urban Indians. With only a few exceptions, funding authority for urban Indian health was limited to Title IV and Title V. All other references to urban Indian health found in other titles address issues of consultation, planning or reporting. Title V provides authority for the I.H.S. to fund health service programs serving urban Indian populations. It serves approximately 149,000 urban Indians in 34 different cities throughout the United States. The programs funded under Title V represent a wide range of services, from outreach and referral programs to comprehensive primary care centers. The amendments recommended by the NSC provides minor changes to the existing law and adds new provisions to Title V. The major changes for Title V include the following:

- To streamline the current law relating to the standard and procedures for contracting and making grants to urban Indian organizations;
- To require the agencies in the DHHS to consult with urban Indians prior to taking actions that would affect them;
- To expand the Secretary's authority to fund, through grants, loans, or loans guarantees, the construction or renovation of facilities for urban Indian programs;
- To enable urban Indian programs to obtain malpractice coverage under the Federal Tort Claims Act, similar to Tribes and community health centers; and,
- To authorize a demonstration program for residential treatment centers for urban Indian youth with alcohol or substance abuse problems.

Language authorizing urban programs the authority to receive advance lump-sum payments for I.H.S. contracts or grants is included in this Title. Reporting requirements have been changed from quarterly to semi-annually, and language is proposed to clarify audit requirements. In addition, the bills authorize funds to be used for facility construction, renovation, expansion, leasing or other purposes. To be consistent, with the redesign of I.H.S., the department title "I.H.S. Urban Branch" was changed to the "Office of Urban Health". Language was added requiring I.H.S. and the DHHS to consult with urban programs on issues affecting urban Indian populations. A new provision proposes to establish at least two (2) urban Indian youth treatment centers as demonstration programs. The bill proposes similar provisions, as is available to Tribes, for access to federal facilities and suppliers. In S.556 Section 512 both the Tulsa and Oklahoma City demonstration projects are made permanent. However, in H.R. 2440, the Tulsa and Oklahoma City urban programs are subjected to ISDEAA but would be "non divisible" to ensure that the program funds would be kept intact.

Title VI – Organizational Improvements

Only a few changes are made in this title. In S.556 Section 601 authorizes the elevation of the Director of the Indian Health Service to any Assistant Secretary for Indian Health. This elevation is consistent with "on-going" Tribal support for this elevation. Unnecessary provisions were deleted in this title if activities had already been completed. New language is in both bills authorizing the I.H.S. to enter into contacts, agreements or joint ventures with other federal or state agencies to enhance information technology.

Title VII – Behavioral Health

Title VII reflect major revisions specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. Section 209 from Title II has been moved to the new Title VII. Where appropriate, the terms "Tribes, Tribal organizations and Indian organizations" are referenced in addition to I.H.S. Provisions that require a "National Plan" were deleted, in lieu of new language establishing a process for locally based behavioral health planning. A broad range of behavioral health services is described under "continuum of care". Several related sections were moved from Title VIII, including sections on Fetal Alcohol Syndrome and Child Sexual Abuse. Demonstration programs were eliminated and replaced with language authorizing programs for Indian Tribes and tribal organizations. The section on Youth Treatment Centers has been amended to allow for at least one center per Area (including Phoenix and Tucson Areas) and retained authority for two treatment "networks" in California.

A new section in this Title authorizes the establishment of at least one in-patient mental health care facility for each I.H.S. Area. These new centers would be funded on a

similar basis as the Regional Youth Treatment Centers. All Tribal-specific programs have been deleted in Title VII, except for facilities operated by the Tanana Chiefs Conference and the Southeast Alaska Regional Health Corporation, with the understanding that continued funding is authorized under general provisions of this Title.

Title VIII – Miscellaneous

Ten Sections were moved out of Title VIII to more appropriate sections in the IHCIA. All Contract Health Services provisions were moved to Title II. A majority of the "free-standing and severability" provisions were incorporated into Title VIII. A listing of all reporting requirements, contained in the bills, have been restated in Section 801 of this title. In S.556 new language negotiated rulemaking procedures is in Section 802. This section also establishes a maximum amount of time for negotiated rules to be printed in the federal register, not later that 270 days after the date of enactment. The authority to promulgate regulations in S.556 expires after 18 months from the date of enactment; thus, expecting the rulemaking process to be completed. In H.R. 2440 Section 802 requires rulemaking applicable to only titles I, II, III, IV, VII, and Section 817; and no regulations are to be issued for titles VI, and VIII. Section 803 of the bills, requires the Secretary, in consultation with Tribes and urban Indian organizations, to develop a "plan of implementation" for all provisions of the Act. Section 804 continues the prohibition on abortion funding, as it exists in current law. Eligibility of California Indians is addressed in Section 806. Health Services for Ineligible persons is included in Section 807 of the bills as it appears in current law, with only minor technical changes.

Section 811 of the bills amends the Eligibility Moratorium and provides that the Secretary shall continue to provide services in accordance with eligibility criteria in effect on September 15, 1987 until such time as new criteria governing eligibility for services is developed.

Finally, a major amendment is reflected in Section 814 of S.556 and in Section 815 of H.R. 2440 with the establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement. The NSC, responding to strong recommendations from the regional and national consultation meetings, examined the establishment of an entitlement provision for Indian health services through the IHCIA reauthorization. The Committee found that a number of issues, related to the establishment of an entitlement provision requires extensive study, research and Tribal consultation. Therefore a Commission is proposed. The Commission will review all relevant data, make recommendations to Congress, establish a "Study Committee", and submit a final report to Congress.

The membership of the Commission will be 25 members, as follows:

- 10 Members of Congress
- 12 persons appointed by Congress from Tribal nominees (who are members of Tribes)
- 3 persons appointed by the Director of the I.H.S. (who are knowledge about health care services for Indians, including at least one specifically nominated by urban Indian programs).

Commission meetings require that a quorum of not less than 15 members be present, to conduct business. The Commission will have the power to hire staff, hold hearings, request studies from the General Accounting Office, the Congressional Budget Office and the Chief Actuary of CMS, and expend appropriated funds. Two reports are proposed. The first report, "Finding and Recommendations", must be made to the Commission by the study Committee no later than 12 months from the date all members are appointed. The second, "A report to Congress: On Legislative and Policy Changes", must be made by the Commission to Congress no later than 18 months from the date all members are appointed.

V. CONCLUSION :

The decision of the NSC to develop bill language, as opposed to general recommendations, required the actual writing of detailed bill language by a "Drafting Team" composed of the NSC co-chairs, tribal attorneys, and program staff. After each drafting session, the full NSC, at its next regular meeting, reviewed the draft language and made any necessary clarifications before its final decisions.

The National Steering Committee completed a monumental task, on time, and with the broad support of Indian Tribes and communities across the United States. There was overwhelming support for the changes described in the NSC proposed bill and for the highly participatory consultation process. We addressed complex and controversial issues and developed consensus solutions that met the needs of those most concerned. There were areas where there was considerable debate which exemplified the complexity and controversy of some issues. A conflict resolution process was approved as one of the NSC's ground rules and used when necessary.

This process of consultation was one of the most rewarding experiences I have been engaged in. I observed that those elected officials who were involved "stepped up to the plate" in an assertive "take control approach" to fulfill what we believe was a major responsibility to Indian Country. Thank you for this opportunity to present testimony on behalf of the National Steering Committee stating our strong support for the reauthorization of the Indian Health Care Improvement Act which is a priority for Indian Country.

Statement of Ben Muneta MD
President
Association of American Indian Physicians
Before the Senate Committee on Indian Affairs
On the Reauthorization of the Indian Health Care Improvement Act
July 16, 2003

Good Morning, Chairman Campbell, and distinguished members of the Senate Indian Affairs Committee I am Ben Muneta, the President of the Association of American Indian Physicians (AAIP), a national medical organization with over 300 American Indian physicians in our membership roster. While the activities of our Association are primarily focused on the recruitment of Indian students into the health professions, we have increasingly been called upon to work in partnership with many health organizations towards eliminating health care disparities among Indian people. We are honored and grateful for he opportunity to provide testimony to the Senate Committee on Indian Affairs.

As a physician and an epidemiologist, I have seen firsthand the health problems and challenges facing Indian communities, and the critical need for additional resources to be devoted to Indian health. I have worked in tribally run clinics, urban Indian clinics, and in various Indian Health Service facilities throughout this nation. American Indians have some of the poorest health indicators in the country. In a Burden of Disease study conducted at Harvard, it was found that American Indian males, in select regions, had the poorest life expectancy in the country. American Indians also live in the poorest counties in the nation and suffer from the many inherent socio-economic problems that go hand in hand with poverty. Indians also have the highest Type 2 Diabetes rate than any other group, Indians have the highest diabetic kidney disease rate, and they have the highest accident rate in the country. It is one thing to read that these disparities exist-it is quite another thing to witness these disparities firsthand in very busy clinics on reservations and in inner cities on a daily basis.

American Indians are the poorest minority in the country with 25.7% living below the poverty line according to the 2000 US Census. They are also the most under-represented minority in the physician field, with only 0.6% of the medical school population in 2000 being classified as Indian.

The importance of having Indian physicians is that they provide a crucial link towards providing quality care in Indian communities. While the provision of health care by the Indian Health Service personnel is excellent there is always a need for more Indian doctors. While there are no specific studies on Indians, studies have shown that in general a higher percentage of minority patients than white patients who see a white physician have less confidence that they will receive adequate health care. More minority patients feel that they are more likely to be treated with disrespect than do white patients. In general, minority

patients more likely to have more difficulty understanding a white doctors instructions or are less likely to question their doctor than would a white patient.

The need to have well-trained, culturally competent health professionals who can address these cultural needs is obvious. An important result of having a minority physician practice in their own communities this is that the quality of care improves in the sense that minority physicians remain for longer periods and get to know their patients better in these communities.

Another issue is access to care. I have done studies on kidney disease in the northern plains and have found that the further a diabetic patient lives from a clinic-the less likely they can come in for routine evaluation of their blood sugars and blood pressure than do those who live closer to a clinic. As a result, the more distant patients are more at risk to suffer from diabetic kidney failure.

We are grateful for the Indian Health Service Scholarship program, authorized under the Indian Health Care Improvement Act which has given the opportunity for American Indians and Alaska Natives to train to fulfill their dream to become health professionals. From these ranks American Indians and Alaska Natives will receive their future medical care from well-trained, culturally competent health providers

We support all provisions in the Indian Health Care Improvement Act that would address the health needs of Indians in reservation and urban areas. We support provisions financing the construction of health care facilities for Indian communities. We support maximizing reimbursement for services from all third party sources.

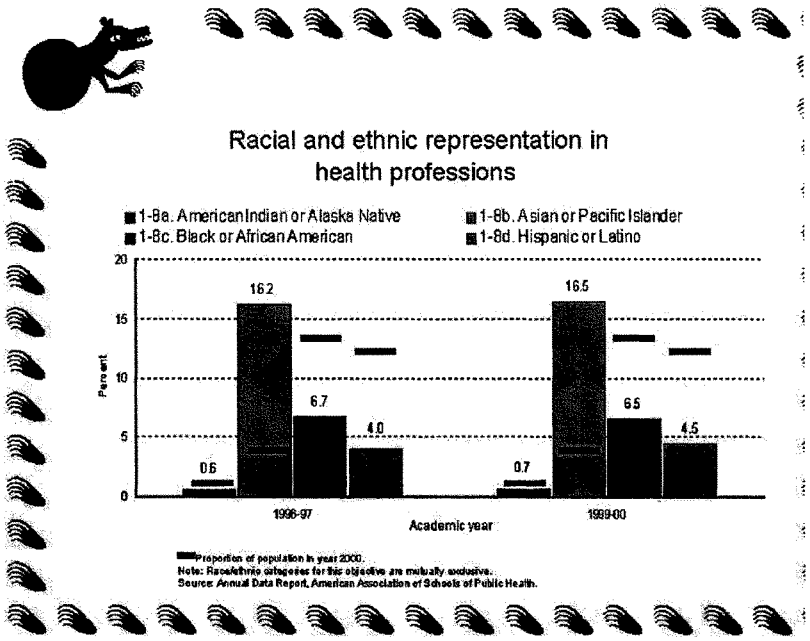
On behalf of the Association of American Indian Physicians, I would again like to thank the Senate Committee on Indian Affairs for the opportunity to provide testimony at today's hearing on the Reauthorization of the Indian Health Care Improvement Act. Our organization is dedicated to be available as a resource to your Committee in support of tribes and Indian organizations involved in delivering Indian health care. We are grateful for the opportunity to support the Reauthorization of the Indian Health Care Improvement Act, and its reaffirmation of the federal trust responsibility to provide health care to American Indians and Alaska Natives. We support the mission of the Indian Health Service to raise the health status of American Indians and Alaska Natives to the highest possible level. On behalf of the Association of American Indian Physicians, I would again like to thank you for this opportunity.

Table 105 (page 1 of 2). Total enrollment of minorities in schools for selected health oc according to detailed race and Hispanic origin: United States, academic years 1970–71 1990–91, and 1999–2000

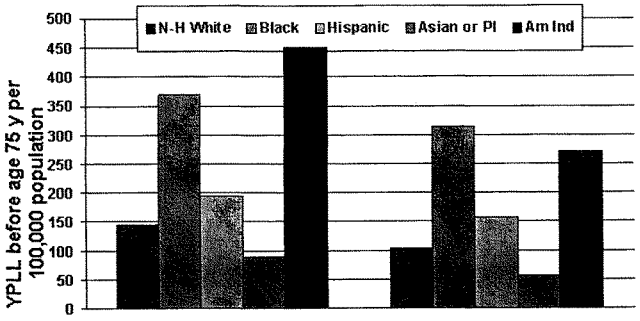
[Data are based on reporting by health professions associations]

Occupation, detailed race, and Hispanic origin	*1970–71*[1]	*1980–81*	*1990–91*	*1999–2000*[2]	*1970–71*[1]	*1980–8*
Dentistry[3]	Number of students				Percent di	
All races	19,187	22,842	15,951	17,242	100.0	100.0
White, non-Hispanic[4]	17,531	20,208	11,185	11,106	91.4	88.5
Black, non-Hispanic	872	1,022	940	808	4.5	4.5
Hispanic	185	519	1,254	912	1.0	2.3
American Indian	28	53	53	99	0.1	0.2
Asian	490	1,040	2,519	4,317	2.6	4.6
Medicine (Allopathic)						
All races[4]	40,238	65,189	65,163	66,444	100.0	100.0
White, non-Hispanic	37,944	55,434	47,893	42,589	94.3	85.0
Black, non-Hispanic	1,509	3,708	4,241	5,051	3.8	5.7
Hispanic	196	2,761	3,538	4,322	0.5	4.2
Mexican	---	951	1,109	1,746	---	1.5
Mainland Puerto Rican	---	329	457	482	---	0.5
Other Hispanic[5]	---	1,481	1,972	2,094	---	2.3
American Indian	18	221	277	574	0.0	0.3
Asian	571	1,924	8,436	12,950	1.4	3.0
Medicine (Osteopathic)						
All races	2,304	4,940	6,792	10,388	100.0	100.0
White, non-Hispanic[4]	2,241	4,688	5,680	8,019	97.3	94.9
Black, non-Hispanic	27	94	217	399	1.2	1.9
Hispanic	19	52	277	370	0.8	1.1
American Indian	6	19	36	65	0.3	0.4
Asian	11	87	582	1,535	0.5	1.8
Nursing, registered[3,6]						
All races	211,239	230,966	221,170	238,244	---	---
White, non-Hispanic[4]	---	---	183,102	193,061	---	---
Black, non-Hispanic	---	---	23,094	23,611	---	---
Hispanic	---	---	6,580	9,227	---	---
American Indian	---	---	1,803	1,816	---	---
Asian	---	---	6,591	10,529	---	---
Optometry[3,6]						
All races	3,094	4,540	4,650	5,313	100.0	100.0
White, non-Hispanic[4]	2,913	4,148	3,706	3,619	94.1	91.4
Black, non-Hispanic	32	57	134	108	1.0	1.3
Hispanic	30	80	186	269	1.0	1.8
American Indian	2	12	21	30	0.1	0.3
Asian	117	243	603	1,287	3.8	5.4
Pharmacy[7]						
All races	17,909	21,628	22,764	32,537	100.0	100.0
White, non-Hispanic[4]	16,222	19,153	18,325	22,184	90.6	88.6
Black, non-Hispanic	659	945	1,301	2,697	3.7	4.4
Hispanic	254	459	945	1,086	1.4	2.1
American Indian	29	36	63	156	0.2	0.2
Asian	672	1,035	2,130	6,414	3.8	4.8

See footnotes at end of table.

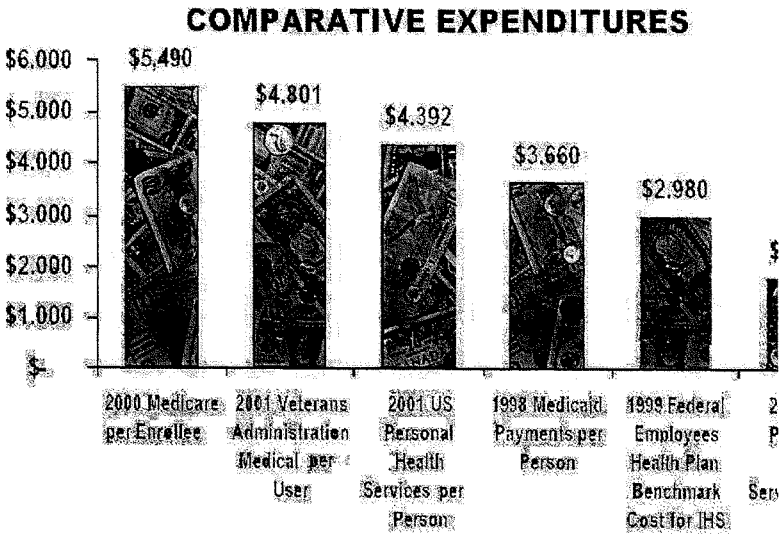

Racial and ethnic representation in health professions
1-8a. American Indian or Alaska Native
1-8b. Asian or Pacific Islander
1-8c. Black or African American
1-8d. Hispanic or Latino
Percent
20
15
10
5
0
16.2
6.7
4.0
0.6
16.5
6.5
4.5
0.7
1998-97
1999-00
Academic year
Proportion of population in year 2000.
Note: Race/ethnic categories for this objective are mutually exclusive.
Source: Annual Data Report, American Association of Schools of Public Health.

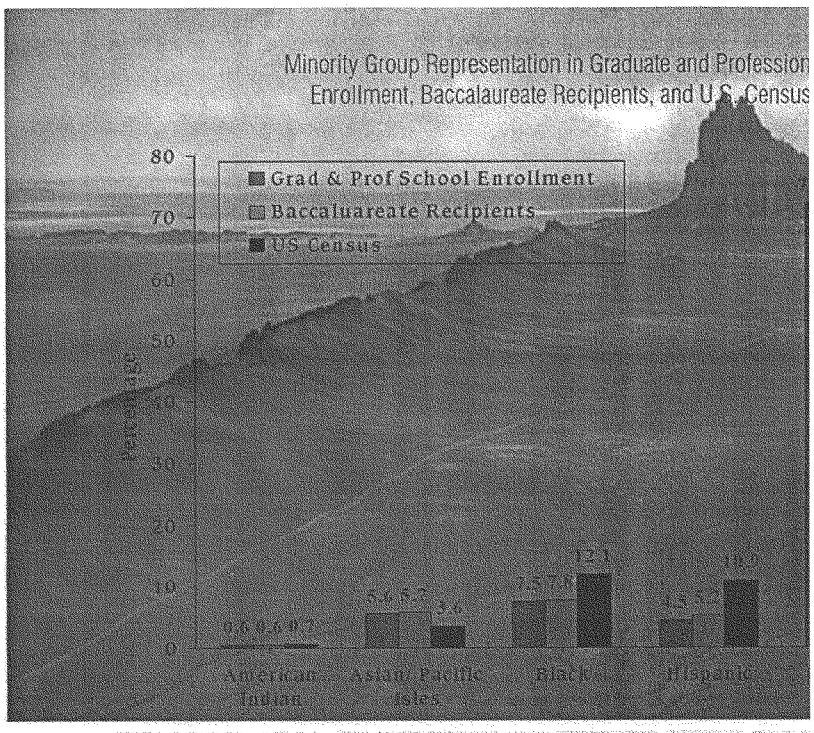
Years of Potential Life Lost to Diabetes



Age-adjusted, 1998 data

Source: National Center for Health Statistics, Health US 2000, table 31


COMPARATIVE EXPENDITURES
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-
$5,490
$4,801
$4,392
$3,660
$2,980
2000 Medicare per Enrollee
2001 Veterans Administration Medical per User
2001 US Personal Health Services per Person
1998 Medicaid Payments per Person
1999 Federal Employees Health Plan Benchmark Cost for IHS



Sources: U.S. Census Bureau, Population Estimates, Population Division, August 23, 2000; T
Almanac, September 1, 2000, p. 24; and National Center for Education Statistics, Integrated

STATEMENT OF STEVEN B. NESMITH
Assistant Secretary
Congressional and Intergovernmental Relations
U.S. Department of Housing and Urban Development

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON INDIAN AFFAIRS

July 16, 2003

INTRODUCTION

Mr. Chairman, Mr. Vice Chairman, and Members of the Committee, thank you for inviting me to provide comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003.

My name is Steven B. Nesmith, and I am the Assistant Secretary for Congressional and Intergovernmental Relations. As you know, Public and Indian Housing (PIH) is responsible for the management, operation and oversight of HUD's Native American programs. These programs are available to 560 Federally-recognized and a limited number of state-recognized Indian tribes. We serve these tribes directly, or through tribally designated housing entities (TDHEs), by providing grants and loan guarantees designed to support affordable housing, community and economic development activities. Our tribal partners are diverse; they are located on Indian reservations, in Alaska Native Villages, and in other traditional Indian areas.

In addition to those duties, PIH's jurisdiction encompasses the public housing program, which aids the nation's 3,000-plus public housing agencies in providing housing and housing-related assistance to low-income families.

It is a pleasure to appear before you, and I would like to express my appreciation for your continuing efforts to improve the housing conditions of American Indian and Alaska Native peoples. Much progress is being made and tribes are taking advantage of new opportunities to improve the housing conditions of the Native American families residing on Indian reservations, on trust or restricted Indian lands, and in Alaska Native Villages. This momentum needs to be sustained as we continue to work together toward creating a better living environment throughout Indian Country.

OVERVIEW

At the outset, let me reaffirm the Department of Housing and Urban Development's support for the principle of government-to-government relations with Indian tribes. HUD is committed to honoring this fundamental precept in our work with American Indians and Alaska Natives.

On behalf of Secretary Martinez, thank you for the opportunity to provide testimony on S. 556. The Department agrees that the Indian Health Service (IHS), a division of the Department of Health and Human Services, is vital to the well-being of individual Indian families and the Native American community as a whole. Native Americans often have no other means to receive the health care assistance and related activities provided by the IHS.

HUD's Office of Native American Programs continues its ongoing dialog with IHS representatives to coordinate our activities in a manner that supports tribal

sovereignty, self-determination and self-governance. The Department also participates in a federal interagency task force on infrastructure with the IHS, Environmental Protection Agency, Bureau of Indian Affairs and Department of Agriculture. It is within this perspective that the following comments are offered on the bill.

BACKGROUND ON HUD NATIVE AMERICAN PROGRAMS

In 1996, the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 et seq) (NAHASDA) became law. NAHASDA changed the way in which housing and housing-related assistance is provided to Native American families. Prior to the Act, Indian housing authorities and Indian tribes applied for a variety of competitive, categorical grant programs, usually with differing program eligibility and reporting requirements. NAHASDA created the Indian Housing Block Grant (IHBG) Program, which is a non-competitive formula grant made to an Indian tribe or its tribally designated housing entity (TDHE).

Under the IHBG Program an Indian tribe or the TDHE submits to HUD a five-year and a one-year Indian Housing Plan (IHP). The IHP contains information about how the recipient will use its IHBG funds to engage in the six affordable housing activities authorized by NAHASDA. Once the IHP is found to be in compliance with statutory and regulatory requirements, the tribe or TDHE executes a grant agreement to receive its IHBG allocation.

The IHBG formula is based on the housing needs of each tribe and the tribe/TDHE's ongoing operation and maintenance needs for the dwelling units previously developed under the Indian Housing Program authorized by the U.S. Housing Act of 1937, as amended. The IHBG formula is calculated by dividing the total amount appropriated each fiscal year among the number of eligible grant recipients. Formula components and variables are weighted to ensure that the complexities and differences among tribes are taken into consideration. Each tribe's formula allocation reflects these factors.

The NAHASDA regulations (24 CFR 1000.306) require that the IHBG formula be reviewed by calendar year 2003 for possible modification or revision. At present, the Department is engaged in negotiated rulemaking (neg-reg) with a 26-member committee comprised of a broad cross-section of tribal stakeholders. The first neg-reg session was held in April; additional monthly meetings are ongoing and scheduled through this September.

SPECIFIC COMMENTS ON S. 556

Let me turn now to our specific comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003.

As you know, the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. The Administration has not taken a position regarding the transfer of NAHASDA funds between HUD and HHS. We do, however, have concerns about transferring NAHASDA funds between Federal agencies when NAHASDA now provides for the direct distribution of IHBG funds to tribes and their TDHEs based on a formula negotiated between tribes and the Department.

An affordable housing activity under the IHBG Program is "development," which includes infrastructure such as site improvements and the development of utilities and utilities services for housing. The provision of water and sanitation facilities is included within this category. Tribes or TDHEs may currently enter into agreements with IHS to provide these services, or they may choose another service provider. We believe this is in keeping with the policy of self-determination that is articulated in NAHASDA.

Since 1997, nearly $28 million has been transferred to IHS through TDHEs for offsite sanitation facilities. Tribes and TDHEs continue to make difficult budgetary and management decisions on how to prioritize their IHBGs, which is consistent with tribal self-determination and self-government.

Let me assure the Committee that we will work with you, our Federal partners in HHS and other Federal agencies, tribes and their TDHEs to ensure that the housing infrastructure needs in Native American communities are met in the most efficient manner possible. We are, nevertheless, concerned about any provisions that might erode the self-determination now provided for in NAHASDA.

Thank you for the opportunity to express our views on S. 556.

Testimony

presented to

The Senate Committee on Indian Affairs

regarding

S. 556 - A bill to reauthorize the Indian Health Care Improvement Act

by

Everett R. Rhoades
Vice-President of the
Central Oklahoma American Indian Health Council, Inc.
Oklahoma City, OK

July 16, 2003

Mr. Chairmen and distinguished members of this committee. My name is Everett Rhoades. Since my retirement as Director of the IHS in 1993, I have had the privilege of serving on the Board of Directors of the Oklahoma City project. I am accompanied by Mr. Rufus Cox, President; Mr. Terry Hunter, Chief Executive Officer; and Ms. Robyn Sunday, Chief Operating Officer of our organization. We are pleased to offer testimony relating to Title V of the Indian Health Care Improvement Act. As one of two special urban health demonstration projects established by the Congress in 1987, we believe that our experiences during the past several years are worthy of consideration by the Congress.

The Central Oklahoma American Indian Health Council, Inc., also known as the Oklahoma City Indian Clinic (OKCIC), is a 100% Indian-controlled not-for-profit corporation established in 1974 to serve the health care needs of American Indians in Oklahoma City. We appear today primarily to call attention of the committee to the circumstances relating to the fact that we, along with the Tulsa program, have certain important issues relating to our status as Demonstration Projects.

Urban Indian Health and Title V of the Indian Health Care Improvement Act

As a result of the Bureau of Indian Affairs Relocation Program during the 1950s and 1960s and other employment opportunities, large numbers of American Indian and Alaska Natives (AI/AN) moved to metropolitan locations throughout the United States. The American Indian Policy Review Commission, established by the Congress, in 1976 estimated that as many as 160,000 American Indians and Alaska Natives were relocated to urban centers during the BIA Relocation Program.[i] While many Indian families did well in the cities, thousands found themselves without basic services, especially health care. Further, although complete data were not available, widespread experience indicated that the general health of most urban Indians in fact was less than for those remaining in traditional Indian communities.

In order to address the serious and growing problem of lack of access to basic health care, a number of the larger cities, such as Los Angeles, Oklahoma City, Tulsa, Seattle, Minneapolis and San Francisco established volunteer Indian centers and free health clinics. However, these were small local efforts and until 1976, urban Indian populations remained largely neglected by the federal health system. Even today, they occupy a relatively minor position in the IHS health care programs. For example, while the IHS provides funding to 34 urban Indian health centers and provides alcohol treatment resources to urban Indian alcohol programs, the FY 2003 appropriation for urban health programs was $31 million. This supports 34 urban programs. The Urban Health Program represents less than 1% of the total IHS annual budget.

The Congress moved to address the growing problem of urban Indian health care and the 1976 Indian Health Care Improvement Act (IHCIA) provided authority for urban health programs through its Title V. This provision authorized the IHS to provide funding to health programs serving urban Indian populations. The enactment of Title V was a pivotal turning point for urban Indian health programs across the nation.

The Oklahoma City Indian Clinic (OKCIC)

As in the case of all the early urban health programs, in the late 1960s a small group of individuals in Oklahoma City established a program designed to provide health services to the large and growing Indian population. Enterprising individuals sought funding from a variety of sources, and through generous donations of professional services and equipment, began to provide the only health care services available for many Oklahoma City Indians. The financial resources available were very small grants from a number of government and nongovernment sources, but not sufficient to sustain any kind of ongoing program. The Oklahoma City Indian Clinic (OKCIC) began as a clinic staffed by volunteer physicians and nurses operating with donated medical supplies and equipment in the standard abandoned store front. While the IHS was not specifically provided funds to establish health care programs in metropolitan locations, it provided minimal amounts of funding, basically for needs assessments in order to estimate the extent of lack of health care in urban locations. Following enactment of P.L. 94-437, modest IHS funding began to become available for urban Indians, including the OKCIC.

Today, the OKCIC serves an eligible population of 45,000 Indians. The Clinic's active patient count is 14,437. The Clinic applies the same criteria used by the Indian Health Services (IHS) for patient eligibility.

The annual cost per patient cared for by OKCIC is far below the national average, at $495 cost per patient. This compares to the IHS average of $1,920, and Medicare's $5,600, and Medicaid's $3,859. Within the constraints of this dramatic under funding, the OKCIC provides state of the art ambulatory care with a highly trained and dedicated staff. The OKCIC was founded as a nonprofit corporation in 1974. In 1977, it received $201,000 from the IHS. The IHS allocation to the OKCIC in FY 2003 is $4,619,664.

Oklahoma Demonstration Projects

Both the Oklahoma City and Tulsa projects originally contracted with the Indian Health Service under Title V of the Indian Health Care Improvement Act as Buy Indian Act contractors. In the years following enactment of the IHCIA, Urban Health Programs remained seriously underfunded and were vulnerable to efforts to reduce their funding even further. In 1987, the Oklahoma Congressional delegation advocated that the two urban programs in Oklahoma become demonstration projects, which would remove their funding from the vulnerable Urban Health account and provide funding through the IHS Hospitals and Clinics account. The Oklahoma City and Tulsa urban Indian clinics were designated Demonstration Projects by the U.S. Congress through a line-item appropriation in the Fiscal Year 1987 Interior Appropriations Act. Specifically, Congress provided:

> *within the amount provided, the Committee has transferred $1,000,000 from the Urban Health Program for a demonstration project to integrate the Oklahoma City and Tulsa projects with the Direct Care Program. (Senate Report No. 99-397)*[ii]

The Congress clearly intended that these programs be regarded as integral units of IHS programs with the clear expectation that they receive a larger *and more equitable allocation* of IHS resources. However, while some increases were realized, they were far below what should have been provided based upon the number of individuals served by each program.

The continuing inequity in resources resulted in further congressional attention. In Fiscal Year 1994, after the IHS provided a comparison of "level need funded" (LNF) to congressional appropriations committee staff, it was clear the two demonstration projects were funded far less, on a per patient basis, than other Service Units in the Oklahoma Area. Following the funding increases specifically provided by the Congress in Fiscal Year 1994, each project replaced their dilapidated facilities, moved into newly constructed facilities, and tremendously expanded services to needy Indians. The special nature of the urban programs is reflected in the now commonly utilized acronym: ITU, which stands for Indian Health Service, Tribal, and Urban programs.

A Hybrid Model

While the Congress clearly intended that these programs be considered the same as IHS Service Units, the IHS contracts with each under authority of Title V. In so doing, the Demonstration Projects continue to meet the definitions described for Title V programs. Both provide services in an "urban center" and each is governed by "an urban Indian controlled board of directors." Thus, the Demonstration Projects are clearly hybrid models, with aspects of both urban and Service Unit programs. For example, the IHS Office of General Counsel's opinion issued on October 4, 1989, said the projects *"...are no longer a part of the Title V urban program but rather are now part of the regular IHS program."* Yet, in other instances the IHS has stated that these programs "as urban programs" could not be fully integrated or funded, as it did in its report to Congress in March 1993 regarding funding for facility construction. In addition, the question of potential contracting of the Demonstration Projects by tribes themselves was addressed.

The question of tribal contracting of either or both of the Demonstration Projects was addressed by the Office of General Counsel on October 22, 1992. In this instance, General Counsel did not address the Title V definitions but relied solely on the new provisions of the 1992 amendments, which *explicitly prohibited such tribal contracting.*

The 1993 Report to Congress stated the Projects were receiving some funding increases for new programs, such as mental health, substance abuse, AIDS/HIV prevention and public health nursing, but far less than the resources that should have been made available based upon their respective patient populations. The report clearly stated that funding for facility replacement was out of the question because of their status as urban programs. Responding to congressional concern that the demonstration projects continued to occupy dilapidated facilities and were not fairly considered for the IHS facilities replacement priority, the IHS responded:

> *". . . the IHS needs to decide if it should construct Federal health care facilities to house health service delivery programs operated by non-tribal contractors ...An IHS*

determination to place these types of facilities on its health facilities construction priority lists would constitute a major change in health facilities construction policy."[iii]

The projects are not operated exactly like an IHS facility, tribal program or urban program. They are unique. Regardless of this, the programs are integral components of the Oklahoma Area service delivery system. Each maintains its Title V status, as an "urban Indian organization" and is governed by an urban Indian board of directors. Contracts are signed with the IHS under the authority of Title V of the IHCIA and under the authority of the Buy Indian Act. Yet, according to Section 512, the programs are clearly intended to be funded on the same basis as existing IHS Service Units.

Urban Governed Board

Section 4 of the IHCIA provides definitions, which are referenced in Title V for eligible urban Indian organizations and patients. Those include the following:

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection () (1) through (4) of this section.

(g) "Urban center" means any community, which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503 (a)[iv].

In numerous examples, such as board composition, patient billing, and certain resource allocations (diabetes initiative), the programs have been treated like urban programs. In other examples, such as patient eligibility, Medicaid and Medicare billing, categorical funding and mandatory increases, the programs are treated like Service Units. The contract between the IHS and the demonstration projects have not changed since their demonstration status. Each contract still references as its authority Title V of the IHCIA.

Congress Funded New Facilities in FY 94

In the Fiscal Year 1994 Interior Appropriations Act, Congress provided funds for facility replacement. The IHS provided the House and Senate Appropriation Subcommittees with an analysis of local Service Unit needs *including the two demonstration sites* based upon an IHS formula called "Level of Need Funded" (LNF). The comparison was shocking and confirmed the claims of the demonstration sites that they were not being funded proportionately. The following table clearly illustrates these disparities:

Unit/Location	LNF
Claremore Service Unit	75.2%
Tulsa Demonstration Project	59.5%
Shawnee Service Unit	63.5%
Oklahoma City Demo Project	39.1% [v]

Congress, based upon these data, provided explicit instructions to IHS as follows:

> *"It is the Committee's understanding the amount reflected for the Shawnee's unit will be allocated entirely to the Oklahoma City clinic and the Claremore funds are to be allocated to the Tulsa clinic. Within the increase provided, funds may be used for a new lease for expanded space. As discussed above the increased costs of this space must be accommodated within the amounts provided." (Senate Report 103-114)*[vi]

Both Demonstration Projects promptly moved to develop new and expanded replacement facilities as a result of the actions of Congress.

Why the Oklahoma Area is Unique

The entire state of Oklahoma is a "Contract Health Service Delivery Area" (CHSDA). The patients in Oklahoma City and Tulsa are located within the Area-wide CHSDA and are therefore IHS eligible patients, counted by the IHS as a significant percentage of the total user population. When Congress provides funding increases to the IHS based upon LNF, it does so in part by counting the patients in Oklahoma City and Tulsa.

In the preamble to 42 CFR Part 36 Subpart C, the IHS explains that a compelling reason to designate the entire state a CHSDA is the existence of the urban populations in Tulsa and Oklahoma City:

> *"This change (making the state CHSDA) is due to the high incidence of utilization of and dependence on IHS facilities by eligible Indian residents of Tulsa and Oklahoma City. Under the NPRM, if eligible residents of the two cities presented themselves to an IHS facility, they would be eligible for care but if the IHS facility for any reason could not provide the needed direct care, the individuals would not be eligible for contract health services. This makes neither administrative nor programmatic sense due to the reliance the affected population places on IHS for health care services."*(43 Federal Register 34650, August 4, 1978)

Because these Oklahoma City and Tulsa populations are included within the Oklahoma Area-wide CHSDA, it is entirely appropriate for the Congress to maintain the Demonstration Projects to serve them. Further, the allocation of resources for these two programs should be *on the same basis as for other Oklahoma IHS and tribal programs.*

The Oklahoma Demonstration Project is a Resounding Success

Attesting to the success of the Tulsa and Oklahoma City projects has been the provision of state of the art Indian health care programs in modern, clean, well lighted and dignified facilities. With expansion of highly trained administrative and clinical personnel, a wide array of preventive and therapeutic services are provided to large numbers of urban Indian patients, most of whom would otherwise be without health care. Both programs are widely recognized as leaders in the provision of health services for American Indians. They have proved the wisdom of the Congress in establishing the Demonstration Projects.

Two Continuing Issues

Two issues require continued Congressional attention: 1) The equitable distribution of funding increases received by the IHS and the Oklahoma Area and 2) continued protection from tribal attempts to contract for the urban programs or to withdraw their shares from the programs.

Oklahoma City and Tulsa Patients Denied Funds

Despite the explicit instruction in Section 512, the two programs are not funded on the same basis as Service Units of the IHS. While the Oklahoma City and Tulsa populations are included in Oklahoma Area requests for additional resources, the two Demonstration Projects do not share equitably in increased resources received by the Area. Instead, Area funds are divided through tribal consultation among the Oklahoma tribes, with little or no regard for the population numbers of the Demonstration Projects *used to generate these resources*. Each of the two programs has had to continually fight for its rightful proportion of any increases in IHS funding. Only the intervention of Congress in FY 94 resulted in a more equitable allocation of resources, based upon the numbers of individuals in each program. A comparison of user population and funding allocations for the former Shawnee Service Unit is presented in Figure 1, whic illustrates the disproportionate misallocation of resources.

Another example of penalties experienced by the two Deomonstration Projects in the allocation of resources is the distribution of the special diabetes monies. As illustrated in Figure 2, based upon populations served, the awards to OKCIC since FY 98 are far below the amounts that should have been received. For example, in FY 00, the IHS formula indicated that OKCIC should have received $637,169. However, it received only $130,879.

The Area Office has pointed to the existing Section 512 language, insisting that had Congress identified the two Demonstration Projects as "operating units" instead of "service units", they would share in increases. We believe this is an artificial distinction, but in order to resolve the issue, we request that the Congress explicitly designate the Demonstration Projects as operating units. The previous intention of the Congress that these programs be funded on the same basis as all other Service Units, or as the case may be, Operating Units, must be reiterated and made permanent.

Tribal Take-Over of Urban Programs is a Wrong Precedent

Urban programs have always strongly supported tribal sovereignty and continue to do so. The Oklahoma Demonstration Projects are not about tribal sovereignty. The Oklahoma City project provides services to patients belonging to more than 200 tribes located both within and outside Oklahoma. Further, the Oklahoma City clinic is not located within any tribal jurisdiction. Recently, certain tribes have proposed contracting under P.L. 93-638 to contract for the two Demonstration Projects or to withdraw tribal shares from each. Section 512 explicitly prohibits this from happening, and *this provision must be protected and made permanent*. The two Demonstration Projects fill an important void in access to health services for more than 33,000 urban Indians in the Oklahoma CHSDA. Tribal assumption or dismantling of the two demonstration projects would cause disastrous and irreparable harm for the 33,000 urban Indian patients. The tribes would not serve the urban populations. There has been no record or demonstration that tribes in Oklahoma are interested in the health care of Oklahoma City and Tulsa Indians. On the contrary, the real basis for the arguments to take over these programs is a desire to shift funding to tribal clinics and facilities.

The numerous tribal affiliations represented among patients served by the OKCIC indicate that no single tribe could assume the entire operation of this entity. Rather, what is proposed is the

incremental disintegration of the existing program to the point where it becomes ineffective or ceases to exist. Given the tremendous workload each demonstration project carries within the Area, elimination of one or both projects would create irreparable calamity within the total Indian health system in Oklahoma.

If Congress allows tribes to "take over" and/or "take away" the limited funds available to urban Indian health clinics under the authority of the Indian Self-Determination Act, it could start a trend nationally which would threaten one of the most inadequately funded components of the Indian health system, urban health. The other 32 urban programs operate on far less funding than do tribal or IHS facilities. Allowing tribal contracting of Oklahoma City and Tulsa would threaten to eliminate or erode the basic health services available to these populations.

The two demonstration projects have become integral components within the I/T/U delivery system of the Oklahoma Area. There is no excess capacity in other tribal or IHS facilities to absorb the 33,000 urban users if these programs were to be discontinued or eliminated. It is one thing to support the Self-Determination of tribes to take-over and operate federal services that are designed to serve those *tribal populations*. It is entirely inconsistent with P.L. 93-638 to allow tribes to reach beyond their service boundaries to siphon away resources of other effective programs in order to bolster tribal health budgets. Further, the Congress in 1992 expressly indicated that these programs were not to be subject to tribal contracting. We simply request that this provision be made permanent.

Conclusion

Section 512 of the Indian Health Care Improvement Act must provide permanent authority for the Oklahoma Demonstration Projects and protect them from tribal contracting under P.L. 93-638. The Congress has already made a substantial investment in the two Oklahoma Demonstration Projects, including the financing of newly constructed facilities. The success of the programs attest to the wisdom of the Congress in establishing these outstanding programs. It is absolutely critical that the Congress continue to protect the IHS eligible patients in Oklahoma City and Tulsa. Significant and irreparable harm will come to these IHS eligible patients if Section 512 of the IHCIA is not continued or made permanent.

There are no IHS or tribal facilities that could absorb the tens of thousands of patients from Oklahoma City or Tulsa if these programs were eliminated. Further, there are no other health care programs in the metropolitan area that could provide care to these patients. Tribal efforts to take over these Demonstration Programs are an effort to increase much needed funding for tribal programs. We strongly urge substantial increases for both tribal and urban health programs so that these conflicts will be unnecessary.

In addtion to the above concerns, the present system of resource allocations to the Demonstration Projects is seriously inequitable and requires correction.

We urge support for S. 556 section 512 as described below.

SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

'(a) TULSA AND OKLAHOMA CITY CLINICS- Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs ~~within the Service's direct care program~~ and ~~continue to~~ be treated as service units *or operating units* in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.
(Italics: proposed change to S.556)

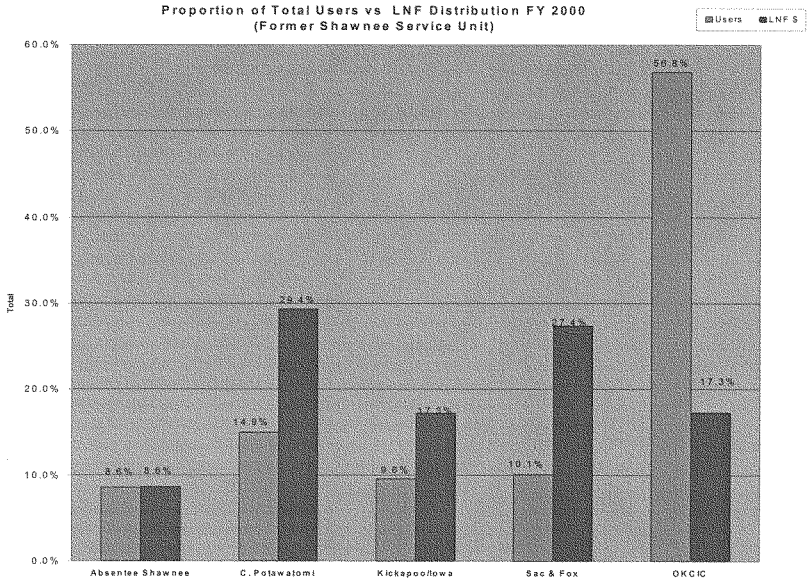

Proportion of Total Users vs LNF Distribution FY 2000
(Former Shawnee Service Unit)
Users
LNFS
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Total
8.6%
8.6%
14.9%
29.4%
9.6%
17.2%
10.1%
27.4%
56.8%
17.3%
Absentee Shawnee
C. Potawatomi
Kickapoo/Iowa
Sac & Fox
OKCIC

figure 1.

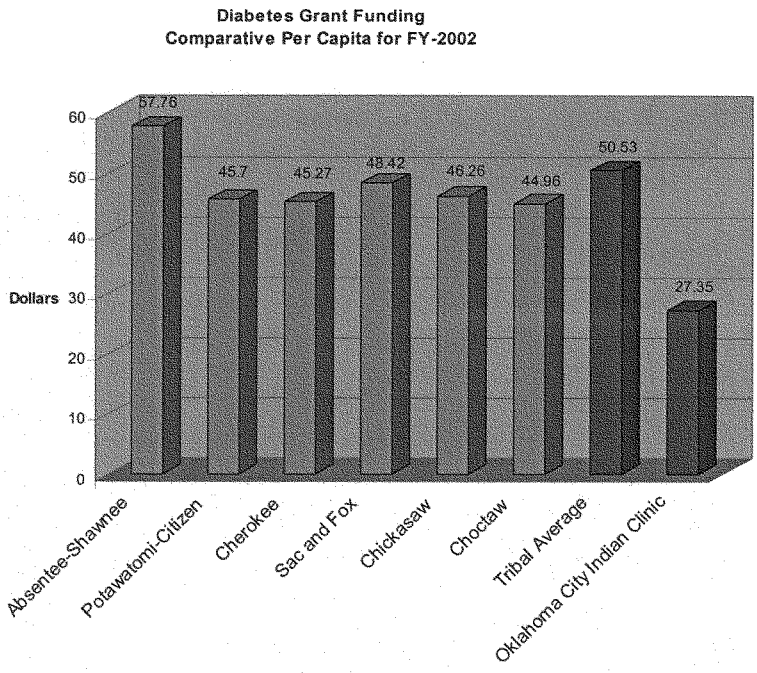

Diabetes Grant Funding
Comparative Per Capita for FY-2002
Dollars
0
10
20
30
40
50
60
57.76
45.7
45.27
48.42
46.26
44.96
50.53
27.35
Absentee-Shawnee
Potawatomi-Citizen
Cherokee
Sac and Fox
Chickasaw
Choctaw
Tribal Average
Oklahoma City Indian Clinic

figure 2.

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i U.S. Congress, American Indian Policy Review Commission, Task Force Report on Off-Reservation Indians, 1977

ii United States Senate Report No. 99-397, to accompany Fiscal Year 1987 Interior Appropriations Act

iii Lincoln, Michel E., Acting Director, U.S. Indian Health Service Department of Health and Human Services, "Report to Congress on the Oklahoma City and Tulsa Clinics in Response to Senate Report No. 102-345" March, 1993

ivIndian Health Care Improvement Act (P.L.94-437), as amended through October 19, 1996 "Annotated Codification" prepared by the Indian Health Service, Legislative Affairs Staff, Office of the Director, April 1998.

v Kauffman, JoAnn, for the Indian Health Service, "Final Report: A comparative evaluation and assessment of the IHS Oklahoma City and Tulsa Indian health delivery sites", 1994.

vi United States Senate, Report #103-114, to accompany the Fiscal Year 1994 Interior Appropriations Act

WRITTEN TESTIMONY

To: Senate Committee on Indian Affairs

Oral Presentation by: Carmelita Skeeter, Executive Director
Indian Health Care Resource Center of Tulsa, Inc.

Re: Section 512 Oklahoma Demonstration Projects
Indian Health Care Improvement Act Reauthorization

July 16, 2003

Good day, Senators, Ladies and Gentlemen. I am Carmelita Skeeter, Executive Director of Indian Health Care Resource Center of Tulsa (IHCRC). Our Urban Indian Clinic is one of the two national Urban Demonstration Projects – our counterpart is the Oklahoma City Indian Clinic.

The Board of Trustees of our nonprofit Urban Indian health organization supports the reauthorization of the Indian Health Care Improvement Act (IHCIA) with language in Section 512 that assures our organization will retain its current ability to manage its own affairs and provide locally directed health care services. As an Indian Health Service Urban Demonstration project, our organization has steadily grown and offers a comprehensive program of outpatient care. Our Urban clinic provides medical, dental, optometry, pharmacy, mental health and substance abuse treatment. What we seek in the renewal of the Indian Health Care Improvement Act is an assurance that our organization can continue to provide health care within the legal structure of the very successful Urban Demonstration delivery system. Last year, our urban clinic received the Outstanding Program award from the National Council of Urban Indian Health.

The Oklahoma Urban Demonstration clinics have proven ourselves to be effective projects and want to continue to operate in the future in the same way that we have functioned since we became Demonstration programs in 1987. **I urge retention of the existing language of Section 512 of the IHCIA Reauthorization Act, which maintains the current status of the two Oklahoma Urban Demonstration Projects as direct care service unit components** of an integrated model of health care within the Indian Health Service delivery system. **I also urge retention of IHCIA Reauthorization Act language that continues to protect the Oklahoma Urban Demonstration programs from the tribal compacting and contracting provisions** of the Indian Self-Determination and Education Assistance Act (ISDEA).

Let me provide a little background and history about the two Oklahoma Urban Demonstration programs. The Indian Health Service provides partial funding to 32 nonprofit Urban Indian clinics and to the two Oklahoma Urban Demonstration clinics. The Indian Health Care Improvement Act enacted in 1976, included the basic Title V authorization for Urban Indian health programs. Nationally, the enactment of Title V was vitally important to the evolution of Urban Indian health care, for it provided an effective means for IHS to partner with community-

based organizations to more effectively serve the basic health care needs of the Urban Indians who comprise over 60% of the nation's American Indian and Alaska Native population.

Due to the instability and inadequacy of Title V funding for Urban Indian Clinics throughout the 1980s, and the overwhelming unaddressed health care needs of Oklahoma's large Indian population, the Tulsa and Oklahoma City Urban Indian health programs advocated for special status as Indian Health Service Demonstration projects. This effort was successful in 1987 when the Interior Appropriation Act moved the funding for the Tulsa and Oklahoma City Urban Indian centers from Title V Urban program to the IHS Direct Care Program (Line Item 01 for Hospitals and Clinics of the IHS annual budget). This action established the Tulsa and Oklahoma City Urban clinics as the only two Urban Demonstration Projects for IHS in the nation.

Since the creation of the Oklahoma Demonstration Projects, the Indian Health Service and Congress have provided a series of incremental interpretations and statements to more clearly define the nature of the Urban Demonstration program and its operations. The two urban health programs do not neatly fit within the IHS/Tribal/Urban framework. Although they came into existence through the Title V Urban Health program, they have moved beyond this origin. When Congress established the Oklahoma Demonstration projects it created a "hybrid," unlike any other in the IHS clinical delivery system. We are independent nonprofit corporations and are not a federal IHS facility. **Our Demonstration status within the I/T/U system has had a positive effect on the level of IHS service unit funding received and the expanded scope of services we are able to provide to Indians in Tulsa and Oklahoma City** and has led to better integration of the Urban programs with the operation of other IHS facilities and programs.

From a tribal perspective, urban clinics, including the Oklahoma Demonstrations are not affiliated with any single tribe – rather, the Urban Demonstration projects maintain an open door to serve members of all tribes. Like all of the Title V Urban clinics, **the designation of the Tulsa and Oklahoma City clinics as Demonstration programs kept in force the Title V language which guarantees the nonprofit corporate independence of all Urban Indian Clinics from the potential of being compacted or contracted** under the provisions of the Indian Self-Determination and Education Assistance Act (ISDEA).

Urban Indian funding was developed by the federal government to provide a means to fill in gaps between Tribal and federal programs. In 1992 Congress enacted P.L. 102-573 stating the following:

> *The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to assure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to affect that policy. (underline added for emphasis)*

Returning to the current situation we face today regarding the reauthorization of the Indian Health Care Improvement Act, extended roundtable discussions were held by the Indian Health Service, Tribal and Urban (I/T/U) system partners for the past three years to consider appropriate language and changes to IHCIA. As you know, these discussions were far-ranging, yet

throughout the process there was strong and clear agreement among the I/T/U roundtable participants that the two Oklahoma Urban Demonstration projects –

1) should be made permanent programs in the IHS direct program;

2) should continue to be treated as Service Units in the allocation of resources and coordination of care while still being treated as a Title V Urban program;

3) should not be subject to the Section 638 Tribal compacting and contracting provisions of the Indian Self Determination and Education Act.

These three provisions were agreed upon nationally by the I/T/U partners and were concretely expressed in the draft Section 512 IHCIA language contained in the 2002 S 212 bill. The Section 512 language of the current IHCIA S 556 bill remains unchanged from last session's S 212 bill.

Today I am here to reiterate the need to keep all three of these components of Section 512 in place as originally agreed upon. **The two Oklahoma Urban projects strongly urge retention of the Section 512 language of S 556 as it was introduced. We absolutely cannot support the language like or similar to the H.R. 2440** which would make the Oklahoma Urban projects "subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible." To make the Demonstration programs projects subject to compacting and contraction would risk compromising and stressing the entire system of care provided to Oklahoma Urban Indians. Compacting and contracting could result in undermining the stability of the Demonstration programs if the tribes were to pull out the base IHS service unit funding from the Demonstration projects.

The Oklahoma Demonstration Projects operate in a unique manner within the Oklahoma I/T/U delivery system. Because the entire state of Oklahoma is designated as a "Contract Health Service Delivery Area" (CHDSA), Oklahoma Indians (including members of non-Oklahoma tribes living in Oklahoma) have the right to receive services from any IHS, Tribal or Urban clinic. The two centrally located clinics operated by Oklahoma's two Urban programs are the most efficient means to serve the diverse intertribal population living in the state's two major Urban areas. The Tulsa metro area has one of the nation's largest concentrations of Native Americans – in the 2000 Census over 86,000 Oklahomans living in the five-county Tulsa MSA responded as American Indians or Alaskan Natives.

The Demonstration status and the corresponding enhanced baseline service unit funding that two Oklahoma Urban Indian clinics receive (as compared being funded at the much lower Title V Urban clinic funding level) has enabled the Tulsa and Oklahoma City Urban Demonstration projects to:

- Construct new clinical facilities, expand clinical services and improve quality of care; the Tulsa Urban clinic has been accredited by the Accreditation Association of Ambulatory Health Centers (AAAHC).

- Maintain continuity of care for a steady stream of patients and clients who move to Urban cities from the rural towns – enabling these patients to transfer their care from rural tribal and IHS health facilities;
- Coordinate care for Urban Indians who access health care at the Urban clinics and at the IHS direct care and Tribally-controlled health programs; we serve as patient advocates to help patients access IHS contract health care and other health services not available at our Urban ambulatory clinics.
- Assist Native Americans qualify for Medicaid and Medicare so they can access additional health care through non-IHS health providers and insurance networks;
- Bill for third-party Medicaid reimbursement as an IHS outpatient clinic at the OMB "all-inclusive" rate generating additional program income to expand services.
- Grow our overall operating budgets. In Tulsa, the Demonstration baseline service unit funding has enabled us to expand our operating budget by more than two and a half times our base IHS funding through grants, contracts and third party insurance billings. As documented in IHCRC's FY 2002 audited annual report, we received $2,672,055 in IHS base funding of our total annual revenue budget of $6,773,763.

The Urban clinics are partners with the federal government and a wide range of community partners. By definition, the contractual partnership which the Urban clinics have with the federal government to deliver health care services requires the Urban clinics to coordinate care with Tribal health programs, as well as IHS controlled health services. Although the Urban clinics operate as partners with the federal and Tribal governments, they operate independently of their direct control. IHCRC and the Oklahoma City Urban clinic are private nonprofit, non-stock membership corporations. IHCRC is a community-based corporation with a local Board of Trustees who are elected by the membership of Indian patients who utilize the clinic's services. Elected Tribal representatives are eligible and have served on the IHCRC Board of Trustees. **The health care our clinic provides to tribal members is provided at no cost to the tribe.**

Establishing Demonstration status, with a corresponding increase in service unit funding, has enabled the two Oklahoma Urban organizations to grow. The two Oklahoma Urban clinics have constructed new facilities through lease/purchase agreements. Although the base IHS funding is helping to finance these new facilities, the principal source of funding that enabled services to be expanded has been through billing for Medicaid reimbursement of services using the OMB rate. Last year, the IHCRC Urban Indian clinic billed nearly $2 million in Medicaid billings. Billing for Medicaid reimbursement under the OMB rate only became possible after the Oklahoma Urbans were designated as Demonstration programs and were recognized as service units within the IHS system. Similarly, for Medicare, Demonstration status allows the two Demonstration programs to receive the cost-based rate available for Federally Qualified Health Centers (FQHCs).

The base IHS service unit funding the Tulsa Urban project (IHCRC) receives represents less than 40% of the annual operating budget of the organization – however it is the core funding that is gives stability of the entire clinical operation. IHCRC has a long track record of success in using the base IHS funding to leverage additional contracts and grants. Private philanthropic and corporate donations were used to help furnish the new IHCRC clinic. In order to receive state substance abuse funding for Indians, IHCRC has served both Indians and non-

Indians for over a dozen years as a state-certified substance abuse contractor. Keeping a patchwork of 10-15 grants in place on an ongoing basis requires organizational stability and maintenance of good relations with the funding sources.

IHCRC has very real concerns that the success of its current business and clinical operations would be threatened if it were to become an object of Tribal politics. IHCRC expanded operations depend on prudent management to maximize Medicaid revenues, to maintain state grants and contracts and to competively compete for other grants. **If the Tribes compacted IHCRC and "pulled the IHS funding out" of the Urban clinic, this action would unravel the entire financial structure and operation of the organization.**

We believe the tribes and the Urbans need to be respectful and supportive of each other's health programs. Indian people do ourselves a disservice when we create divisions that hamper and impede our collective ability to address the health needs of Indian people. One promising example of ongoing cooperation is a six-year partnership in which our Urban clinic, eight Oklahoma tribes and the State Health Department are collaborating. Through a CDC "Racial and Ethnic Approaches to Community Health" (REACH) health disparities grant, each of the Indian partners receives funding to conduct physical activity programs for Indian youth to reduce the lifetime risk of diabetes and cardiovascular disease. Another example – the Cherokee Nation has conducted the WIC nutrition and food program for moms and children in our clinic for over 25 years. Additional information that documents our extensive collaborations with tribes and community partners is attached to my written testimony.

All of us within the I/T/U system need to work together to improve the Indian care health care delivery – and ultimately – to improve the health of our Indian people. Recently, the Oklahoma I/T/U system of 41 health facilities operated by the Indian Health Service, Tribes and Urban organizations has been given an opportunity by the Oklahoma Health Care Authority and the federal Centers for Medicaid and Medicare Services (CMS) to develop a model Medicaid program for Oklahoma Indian people. A concept paper describing an expanded partnership between the state Medicaid agency and I/T/U has been submitted to CMS in anticipation of a full revision to the Oklahoma 1115 Medicaid waiver. This waiver will provide a special opportunity to further grow and develop the Oklahoma's I/T/U delivery system into a more integrated system of care through OMB Medicaid reimbursement available to I/T/U programs. Indian Health Care, in its role as Urban Indian Demonstration program, looks forward to being an active participant in making this proposed statewide Indian Medicaid 1115 Demonstration waiver a success.

Since 1995, when Oklahoma initially implemented its Medicaid managed care delivery system, the I/T/U programs and the Oklahoma Health Care Authority have worked to adapt to challenges and changes of the managed care delivery systems and to maneuver the regulations required both for the Medicaid program and the I/T/U facilities. Indian clients have had perhaps the biggest challenge in navigating through these systems to receive Medicaid services. The proposed Oklahoma I/T/U Medicaid waiver has great potential to streamline the Medicaid program for Indian people and offer improved access to an expanded set of desperately needed health care services within the I/T/U network of IHS, tribal and Urban health facilities.

In closing, the Tulsa and Oklahoma City Urban Clinics believe the health care of Indian people is best served by a Indian health delivery system that ensures the continued presence of the federal Indian Health Service programs and initiatives, Tribal health services and Urban programs operated by locally-controlled Urban Indian nonprofit organizations. Indian Health Care Resource Center functions both as a major provider of I/T/U services and as a key local provider of essential safety net health care services within the general Tulsa community.

The health care needs of Oklahoma Indians are too critical to risk the operation of the Oklahoma Urban Demonstration Projects to the uncertainties of Tribal politics. The health needs of vulnerable Tulsa and Oklahoma City Indian people should not be allowed to be caught in a struggle among Oklahoma tribes.

Conclusion

I urge the Senate and Congress to reauthorize the Indian Health Care Improvement Act with the language of Section 512 in the "as introduced" version of Senate Bill 556, which would make permanent the current "Demonstration" status of IHCRC and its Oklahoma City Indian Clinic counterpart, protecting the two Oklahoma Urban clinics from tribal control and guaranteeing they continue to receive their fair share of IHS service unit funding for the population they serve. It is also very important that the Oklahoma Demonstration Projects continue to be able to provide care to patients with Medicaid and Medicare insurance coverage and receive appropriate OMB and FQHC reimbursement.

* * *

IHCIA SECTION 512 – LANGUAGE RECOMMENDATION

The Oklahoma Urban Demonstration Projects strongly support the language of S. 556,
SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

(a) TULSA AND OKLAHOMA CITY CLINICS – Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic Demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an Urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

The Oklahoma Urban Demonstration absolutely cannot support the language of H.R. 2440,
SEC. 512 TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

TULSA AND OKLAHOMA CITY CLINICS – Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic Demonstration projects shall –

(1) be permanent programs within the Service's direct care program;
(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and
(3) shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible."

Brief IHCRC History and Background

Indian Health Care Resource Center (IHCRC) was founded more than 27 years ago in order to give Indians living in Tulsa more convenient access to health care – previously they had to travel 30 miles to receive care at the Claremore Indian Hospital. Through the years, IHCRC has steadily grown to become a major medical clinic with a wide range of services. In 1999, the IHCRC Board developed a lease/purchase funding package that enabled the clinic to move from its former cramped and deteriorating location to a modern, much larger facility. The new medical facility and clinical operation is accredited by the Accreditation Association for Ambulatory Health Care.

The comprehensive health care offered at Indian Health Care is truly impressive. It includes medical, prenatal and dental care, pharmacy, optometry, Indian family services, behavioral counseling and substance abuse treatment. Other services include lab, x-ray, mammography, cardiovascular and diabetes care, health education, preventive care and WIC nutritional foods. Indian Health Care Resource Center serves over 15,000 active patients from more than 150 tribes.

***Mission**: The mission of Indian Health Care Resource Center is to provide quality, comprehensive health care to Tulsa area Indian people in a culturally sensitive manner That promotes good health, well being and harmony.*

***Vision:** Indian Health Care Resource Center is committed to the elimination of health disparities, the expansion of innovative family-focused practices and the promotion of an embracing approach to care that strengthens physical, mental, emotional and spiritual wellness within the Indian community.*

Oklahoma Indian Health Status

Oklahoma has an estimated 391,419[1] Native Americans, the second largest Native American population in the nation. As with other populations of color, Native Americans face a disproportionate share of health problems compared to the general population, including:

- Oklahoma's Native American population has a smoking rate of 33%[2] and rate of obesity 66%[3], which are two contributors to heart disease, the leading cause of death for Indians in Oklahoma.
- The rate of diagnosed diabetes is 2.6 times higher in Native Americans than non-Hispanic whites.
- Diabetes complications[4]:
    - The rate of end state renal disease is six times higher in Native Americans than the general population.
    - Amputation rates are 3-4 times higher
    - Rate of diabetic retinopathy is 24.4% in Native Americans.
- The proportion of Native American women with no prenatal care[5] in first trimester was 31.2 in 1998, which is 2.6 times higher than white non-Hispanics (12.1).
- The Breast Cancer[5] age-adjusted death rates increased from 9.9 in 1990 to 19.3 in1998.
- The Lung Cancer[5] age-adjusted death rates increased from 19.6 to 25.1 in 1998.

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[1] United States Census, 2000.
[2] Oklahoma State Health Department, 2002 State of the State's Health Interim Report.
[3] Kaiser Family Foundation State Health Facts Online.
[4] Diabetes Among Native Americans, American Diabetes Association Webpage.
[5] Keppel KG, Pearcy JN, Wagener DK. Trends in racial and ethnic-specific rates for the health status indicators: United States, 1990-98. Healthy people statistical notes, no. 23. Hyattsville, Maryland: National Center for Health Statistics. January 2002.

IHCRC Cooperative Activities with Tribes and the Community

Tribal Collaborations

- In Fall 2002, the Cherokee Nation and the Muscogee Creek Nation behavioral health and substance abuse departments met with IHCRC to conduct strategic planning with an objective of expanding treatment services, including opportunities to collaboratively and collectively compete for grants in federal minority health, education, juvenile justice, substance abuse and mental health arenas. The group met with Terry Cline, the Director of the Oklahoma Department of Mental Health and Substance Abuse Services, to discuss approaches for the State and Indian organizations to partner in efforts to develop a continuum of mental health and substance abuse services.
- IHCRC provides Substance Abuse treatment services to the Creek Nation Sapulpa Indian Clinic
- For more than 25 years, IHCRC and has maintained a contract for the Cherokee Nation to offer WIC services in our clinic.
- Another example of ongoing tribal cooperation is a six-year partnership in which our urban clinic, eight Oklahoma tribes and the State Health Department are collaborating. Through a CDC REACH health disparities grant, each of the Indian partners receives funding to conduct physical activity programs for Indian youth to reduce the lifetime risk of diabetes and cardiovascular disease.
- The Oklahoma I/T/U system of 41 health facilities operated by the Indian Health Service, Tribes and Urban organizations are working together with the Oklahoma Health Care Authority to develop a model Medicaid program for Oklahoma Indian people that will be submitted as an amendment to the Oklahoma 1115 waiver.

Community Collaborations

IHCRC is an active partner in a wide variety of community and state public health partnerships. A brief summary of these collaborations follows.

- IHCRC is an active participant in Oklahoma's Turning Point initiative that links local community activism to raise consumer awareness about the need for individuals to take greater personal responsibility for their health.
- IHCRC is a Healthy Start contractor in a community partnership to reduce infant mortality that includes smoking cessation and anti-depression programs.
- In addition to working with local and state health departments, our agency also works closely with other community health and social services agencies to address major public health concerns including the perinatal health, immunizations, AIDS, tuberculosis, chronic diseases, drug abuse, homelessness and domestic violence. IHCRC is an active member of the Native American Diabetes Coalition, Oklahoma Primary Care Association, the Tulsa Family Health, the American Red Cross, the Homeless Services Network, the Tulsa Immunization Coalition, and the Tulsa Community Aids Partnership.
- For eight years IHCRC has been part of Community HealthNet, a community consortium of Tulsa's nonprofit providers of primary health care with the goal of increasing access to health care for persons without health insurance or on public assistance. Last year, Community HealthNet received a substantial ($880,000) federal HRSA Community Access Program (CAP) infrastructure development grant. The CAP grant is being used to establish internet-based client referral and case management system that will help integrate and coordinate patient care among the community's multiple agencies that provide health and human services.
- IHCRC recently assisted Community HealthNet and other community partners apply for HRSA Bureau of Primary Care Section 330 funding for a new community health center and designate a new Medically Underserved Area in collaboration with the State Health Dept. Office of Primary Care.
- IHCRC's Behavioral Health Department recently established a graduate psychology student internship program, which collaborates with area universities.

Specific Collaborations between the Cherokee Nation and Indian Health Care Resource Center of Tulsa, Inc.

Indian Health Care Resource Center (IHCRC) was established in 1976 as an outreach program of the Native American Coalition of Tulsa. IHCRC was formally incorporated in 1978 as a separate nonprofit organization with a community-based board.

- In 1976 the Cherokee Nation established a satellite WIC nutrition program in IHCRC's clinic. This operation has continued in operation continuously to date.
- Cherokee tribal members, including elected Cherokee Tribal Council members, have served on the IHCRC board throughout the years. Currently, Cherokee tribal members comprise more than half the IHCRC Board of Trustees.
- The Cherokee Nation and IHCRC collaborated with seven other Oklahoma tribal nations and the State Health Department to establish the Oklahoma Native American REACH 2010 Coalition partners. Funded at $1 million/year for six years, this grant program promotes physical activity to reduce lifetime risks of diabetes and cardiovascular disease. The other participating tribes in the Oklahoma Racial Equality Achievement in Community Health (REACH) 2010 Coalition are the Absentee-Shawnee, Cheyenne-Arapaho, Chickasaw, Choctaw, Pawnee, Seminole, and the Wichita and Affiliated Tribes. Sponsored by the Centers for Disease Control, the REACH program is intended to eliminate health disparities among minority people and the nation.
- For many years, IHCRC has made its clinic available as a community location for tribal enrollment.
- IHCRC provides its clinic as a community polling place for members of the Cherokee Nation to conduct its tribal elections.
- IHCRC provides its clinic as a community location to hold tribal press conferences for the Tulsa media.
- IHCRC is currently providing clinic space for a tribal representative to market its HUD home improvement grant program.
- Recently, IHCRC was an active participant in the Cherokee Nation 15-Year Health Plan.
- Cherokee Nation has provided a letter of support to IHCRC affirming that the Tulsa Urban program addresses critical Indian health needs and that the Tulsa program should continue to be governed as a nonprofit organization with an elected community board.
- As requested by the Cherokee Nation, IHCRC has provided Letters of Support to the Tribe for grant applications.
- IHCRC and the Cherokee Nation are coordinating their two federal Substance Abuse and Mental Health Services Administration (SAMHSA) community planning FY 2002 grants to improve the availability of comprehensive substance abuse treatment services.
- On a routine basis, the Cherokee Nation and IHCRC coordinate clinical referrals between the two health organizations, including substance abuse referrals to the Cherokee Nation's Jack Brown substance abuse residential treatment facility for Indian youth.
- On a routine basis, the Cherokee Nation and IHCRC coordinate referrals for the Cherokee Indian Child Welfare and the Oklahoma Department of Human Services (DHS).

JUL-28-2003 11:37 FROM:INDIAN HEALTH CARE 9183821297 TO:202 224 5429 P.002/004

Response to: IHCIA Testimony Questions

Requested by: Senator Ben Nighthorse Campbell, Chairman
Senate Committee on Indian Affairs

Response from: Carmelita Skeeter, Executive Director
Indian Health Care Resource Center of Tulsa, Inc.

Re: Section 512 Oklahoma Demonstration Projects
Indian Health Care Improvement Act Reauthorization

July 28, 2003

1. Your clinic has been very successful, and I understand that you want it to be made permanent.

a) What advantages do you anticipate if the demonstration is made permanent?

Being made a permanent demonstration program would ensure organizational stability and continuity of provision of services. If our current operations can continue uninterrupted, we will continue to provide quality health care in a convenient urban setting where the local urban Indian population can easily access services. Being treated as a permanent service unit will enable us to continue to receive enhanced funding over the standard Title V Urban Indian funding rate – we receive more than double the IHS funding that a Title V Urban program receives.

The Oklahoma Urban Demonstration Projects were undertaken as an experiment to improve health care. The base IHS funding which the demonstration projects receive serves as the foundation from which the two successful programs are able to operate. The intent of the Oklahoma Demonstration projects was to give the two urban program access to increased IHS funding, OMB Medicaid billing and other resources that the Title V Urbans do not receive.

The Oklahoma Urban Demonstration clinics have proven ourselves to be effective projects and want to continue to operate in the future in the same way that we have functioned since we became Demonstration programs in 1987. Our organization seeks to retain its current ability to manage its own affairs and provide locally directed health care services. As an Indian Health Service Urban Demonstration project, our organization has steadily grown and offers a comprehensive program of outpatient ambulatory. What we seek in the renewal of the Indian Health Care Improvement Act is an assurance that our organization can continue to provide health care within the current legal structure of the very successful Urban Demonstration delivery system.

The current federal law for the Oklahoma Demonstration Projects (P.L. 94-437 Section 512) states, "Notwithstanding any other provision of law, the Oklahoma City

Clinic demonstration project and the Tulsa Clinic demonstration project as service units in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination Act for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs."

Importantly, IHCRC is currently working together with Oklahoma tribes and the Oklahoma City Area Intertribal Health Board to improve Medicaid and SCHIP services for Indians through the submission of a special Medicaid waiver. The Oklahoma Indian health system of 41 facilities operated by the Indian Health Service, Tribes and Urban organizations (I/T/U) has been given an opportunity by the Oklahoma Health Care Authority and the federal Centers for Medicaid and Medicare Services (CMS) to develop a model Medicaid/SCHIP program for Oklahoma Indian people. A concept paper describing an expanded partnership between the state Medicaid agency and I/T/U is about to be submitted to CMS. The proposed I/T/U waiver provides a special opportunity to further grow and develop the Oklahoma's I/T/U delivery system into a more integrated system of care through OMB Medicaid reimbursement available to I/T/U programs. Indian Health Care, in its role as Urban Indian Demonstration program, looks forward to being an active participant in making this proposed statewide Indian I/T/U 1115 Demonstration waiver a success.

If Oklahoma is to build the capacity of the I/T/U system to serve an expanded Medicaid and SCHIP population, it is then obviously important that the Tulsa and Oklahoma City Urban Indian programs be kept intact so that they can expand services in the urban population areas where many of Oklahoma's Indians live.

b) Do any tribes have health care facilities within the Tulsa urban area?

No. The Muscogee Creek Nation operates a tribal clinic in Sapulpa, located approximately 20 miles southwest of Tulsa. Approximately 30 miles northeast of Tulsa, the Indian Health Service operates an outpatient clinic and hospital in Claremore, which is located in the Cherokee tribal jurisdiction. Many Tulsa urban Indians do not have personal transportation to travel to these rural clinics. No public transportation is available either.

c) If your clinics were allowed to be "compacted," who would provide services to Tulsa's urban population?

Both the aforementioned clinics are currently operating at over capacity. There would be no available Indian facility available to meet the needs of Indians living in metro Tulsa. If our Indian clients were to seek health care from non-Indian Health Service providers, they would have little success. Existing community safety net health providers are already stressed and would be unable to accommodate the influx of the 15,000 active patients we see in Tulsa.

2. As I understand your testimony, your clinic has made a substantial financial commitment for new facilities. If IHS funding were pulled you might have to default on some of those commitments . . . Have you taken any steps to lessen the likelihood of defaulting on some of those commitments?

With our current IHS funding arrangement it has not been necessary to take any steps to date. In a 1992 IHS Appropriation Bill we were awarded an increase of $325,000 in annual appropriations for lease payment for expanded space. We have a letter on file from IHS that states that the lease/purchase basis used to finance our facility was the most cost-effective arrangement to expand our clinical space. We are bound by legal language of our lease /purchase arrangement with Bank One Capital Corporation to retire 15 year bonds. We currently have 12 years outstanding on our bonds and a balance of approximately $3 million. The approximate annual payment for principal and interest due on the bonds is $325,000. In the event that that tribal compacting/contracting occurred and resulted in a loss of our IHS funding, we would be forced to make reductions in patient health care and then redirect operating funds to cover the facility lease (debt service).

3. I know that urban areas often attract Indian people from many different tribes and reservations. Can you give us an idea of how many different tribes are represented among your list of patients?

We have approximately 15,000 unduplicated active patients. These patients are members of more than 150 different tribes. As illustrated on page 24 of the 2002 IHCRC annual report, members of the Cherokee Nation represent 42% of all our patients, Creek patients total 25% of all patients, Choctaws total about eight and half percent, Osage patients total about three percent and Seminoles total about two and half percent. Non-Oklahoma based tribes total about seven percent of all patients. Our patient population is constantly growing – we enroll over 200 new patients to the clinic every month.

NATIONAL AMERICAN INDIAN HOUSING COUNCIL

Testimony of Russell Sossamon, Chairman

SENATE COMMITTEE ON INDIAN AFFAIRS
HOUSE RESOURCES COMMITTEE
FOR THE JULY 16 HEARING RECORD

S. 556 and H.R. 2440
Indian Healthcare Improvement Reauthorization Act of 2003

On behalf of the National American Indian Housing Council, I would like to thank Chairman Campbell, Vice Chairman Inouye and the Senate Indian Affairs Committee, as well as Chairman Pombo, Ranking Member Rahall and the House Resources Committee for the opportunity to submit testimony on the limitations that tribes face in using Indian Health Service Sanitation Facilities Construction funds to provide water and sewer infrastructure for homes built from the full range of Indian housing funding sources. The provisions of S. 556 and H.R. 2440 pertinent to this issue can be found in section 302 of each bill.

While thousands of new homes are being built throughout Indian Country every year, quality community development continues to be hampered by restrictions in legislation which has had an adverse impact on many tribes. The inclusion of a provision in the Department of Interior Appropriations bill that has existed since 1982 has contributed to a sanitation infrastructure crisis for many tribal communities. Under the appropriations provision, Indian Health Service funds are not to be used for building sanitation infrastructure serving Housing and Urban Development Department funded homes. The harmful effects of this provision have been brought to the forefront recently due to an increase in the number of homes being built and a decrease in overall infrastructure funding levels. The prohibitive language is also contained in the Indian Healthcare Improvement Reauthorization Act of 2003, as referenced above.

Over the past decade, the number of new homes built per year in Indian Country has increased from 2,000 homes prior to 1996 to more than 25,000 since the implementation of the Native American Housing Assistance and Self-Determination Act (NAHASDA) began. The cost to serve 2,000 new homes with adequate sanitation facilities was about $20 million. The

estimated cost to serve 25,000 new homes is estimated at $250 million; and while traditionally the Indian Health Service has had the responsibility for providing health facilities for the tribes, current Indian Health Service funding to serve this need is $0. Because Indian Health Service funds are not allowed to be used for building infrastructure for newly constructed HUD homes, many tribes are placed in the unenviable position of having to choose between building much needed new homes or supplying much needed infrastructure. Furthermore, if a project has been financed with multiple funding sources, only that portion funded by HUD must be separated from being served by I.H.S. If a tribe does not receive supplemental infrastructure funding, many times as much as 50% of the tribe's housing funds go to the construction of infrastructure, contributing little against the growing need for homes. Considering the fact that there is an estimated current need for 200,000 new homes in Indian Country, spending only half of the federal funds appropriated for a housing program actually on housing cannot be the best use of a housing program.

Currently, most housing programs rely on a number of different funding sources gathered from various agencies for all of their needs. In fact, the NAHASDA program was built partly on the premise of leveraging funds from both public and private sources. This is the trend for federal tribal programs – a shift towards community development tapping into multiple resources, rather than sporadic project-based assistance. Why should provision for sanitation facilities construction be singled out?

The prohibition against using Indian Health Service funds for HUD homes is outdated. When the prohibition began, HUD would fund complete projects for tribes, factoring in infrastructure along with whatever else was needed. Now that tribal housing is block granted, tribes must be creative to make their finite dollars stretch. With housing funding that has increased only $50 million in six years, HUD's programs certainly cannot be expected to meet 100% of tribes' housing needs. While tribes' have become very resourceful in seeking alternate funding from all agencies and the private market, the prohibition on Indian Health Service funds is like hitting a brick wall at the same time that other agencies are working together to open barriers for tribal development.

This is more than a funding issue. Forcing tribes to single out that part of their housing development funded by HUD and find alternate funding for its infrastructure causes an unnecessary accounting and engineering burden. To have the Indian Health Service funds available to fulfill this infrastructure need for all other tribal homes, yet unusable for tribes' major housing program due to a government policy designed to protect appropriations jurisdictions makes absolutely no sense.

Under the current regime, communities end up with either newly built HUD homes that lack sufficient sanitation infrastructure or with improved infrastructure capabilities but a terribly low housing supply. In fact, in some communities the situation can be so ridiculous that one side of the street may be lined with HUD homes completely shut off from all sanitation services, while the other side of the street lined with Bureau of Indian Affairs or US Department of Agriculture funded homes, is covered by the Indian Health Service and their sanitation infrastructure funding. The fact that proper sanitation infrastructure for tribal communities and housing developments are at the mercy of a provision arising out of interagency funding rivalries is something that needs to be addressed so that good administration and reduced bureaucracy can be achieved by tribes. Accounting ingenuity and resources wasted on needless red tape can not be what policy makers intend when they continually introduce this provision.

The National American Indian Housing Council believes the tribes themselves should have more control over how to maximize the funding available from the various federal Indian housing programs. Eliminating the prohibition of using Indian Health Service funds for HUD homes will remove a major bureaucratic barrier the tribes face in addressing housing and infrastructure needs. In an effort to build homes and provide proper infrastructure, tribes themselves should be the ones with control over how to use the funding they receive from the various housing programs. If this burdensome provision is removed, tribes could plan rationally for the provision of sanitation facilities funding for their housing projects as a whole. Out of respect for sovereignty and self-determination the decision should be with the tribe as to how and where the funding would best be utilized. Under this type of system, tribes could maximize their ability to provide both housing and infrastructure to their communities rather than choosing one over the other. Local tribes and communities know how and where to utilize their resources in effective and efficient ways. If local communities had free reign to allocate funds they way they saw fit, no community would have a street where half the houses have sanitation infrastructure while the other half do not. Ensuring that this provision is eliminated from the Indian Health Care Improvement Reauthorization Act is certainly a step in the right direction.

We understand that the Indian Health Service has a tremendous backlog of need for the grossly under-funded Sanitation Facilities Construction program. We don't see that as being the issue – the Indian Health Service desperately needs more funding. However, as plainly demonstrated in a recent report of the Civil Rights Commission, "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country," *all* Indian programs are grossly under-funded, including housing. We feel that the best policy in such an environment is to allow tribes as much access and flexibility as possible to meet the unique needs of their individual tribe. The recipient is the same whether BIA, USDA, IHS, or HUD programs are being utilized – it is for the betterment of the tribe, so to frame this as a competition for the use of the different program funding is to not see the big picture of comprehensive tribal planning and development.

National American Indian Housing Council is a 501(c)(3) organization representing tribes and tribal housing organizatio nwide. It operates a national technical assistance and training program as well as the Native American Housing Resourc er in Washington, DC through an appropriation from the Congress administered by HUD. NAIHC's offices are at 900 nd Street, NE, Suite 305, Washington, DC 20002; phone: (202) 789-1754, fax: (202) 789-1758; http://www.naihc.net.

Testimony of

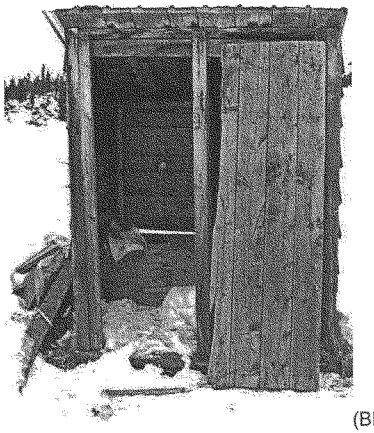
STEVEN WEAVER

Director, Division of Environmental Health and Engineering
Alaska Native Tribal Health Consortium

Before a Joint Hearing of
The Senate Committee on Indian Affairs
and
The House Resources Committee

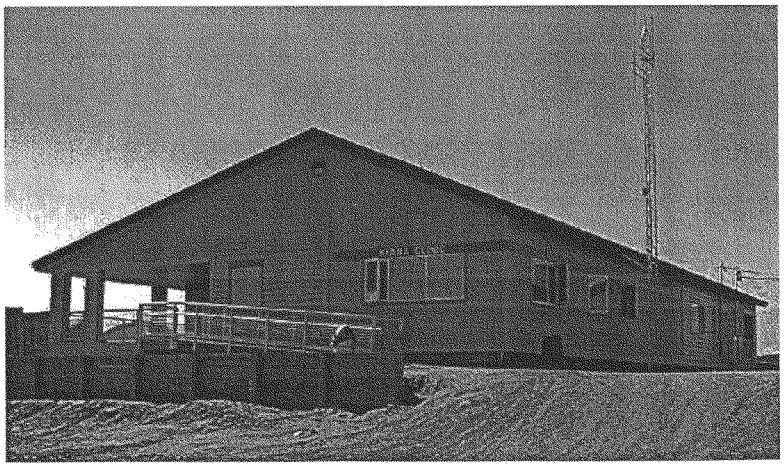
Regarding the Health Facilities and Sanitation Provisions of
S. 556 and H.R. 2440,
Bills to Reauthorize the Indian Health Care Improvement Act

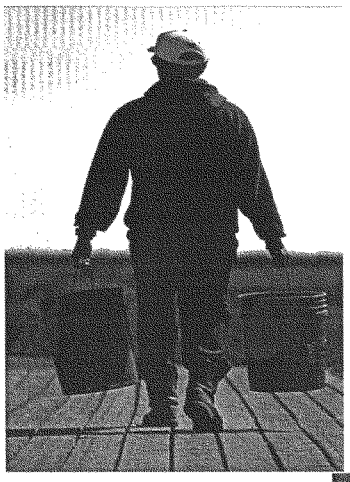
July 16, 2003



(LEFT) OUTHOUSE:
The only lavatory available to the health clinic in Lime Village, Alaska is a dilapidated outhouse.

(BELOW) HEALTH CLINIC: The newly constructed health clinic in Kiana, Alaska. This facility contains a completed piped water and sewer system.





(LEFT) HONEY BUCKETS:
For decades, honey buckets have defined rural Alaskan sanitation standards. While practical, their use and disposal create unsanitary living conditions that expose people to disease.

(RIGHT) PIPED WATER AND SEWER SYSTEMS:
Permafrost (permanently frozen soil) prevents water and sewer utilities from being buried in many northern Alaskan communities.

Piped water and sewer systems allow for no exposure to human waste and provide a dependable, year-round water source for community members.

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Testimony Of

STEVEN WEAVER

Director, Division of Environmental Health and Engineering
Alaska Native Tribal Health Consortium

Before a Joint Hearing of
the Senate Committee on Indian Affairs and
the House Resources Committee

Regarding
Health Facilities and Sanitation Provisions of S. 556 and H.R. 2440
Bills to Reauthorize the Indian Health Care Improvement Act

July 16, 2003

Chairman Campbell, Chairman Pombo, and members of the Committees, thank you for the opportunity to testify regarding S. 556 and H.R. 2440, the Senate and House bills that would reauthorize the Indian Health Care Improvement Act. I appear today on behalf of the Alaska Native Tribal Health Consortium (ANTHC), where I serve as Director of the Division of Environmental Health and Engineering (DEHE).

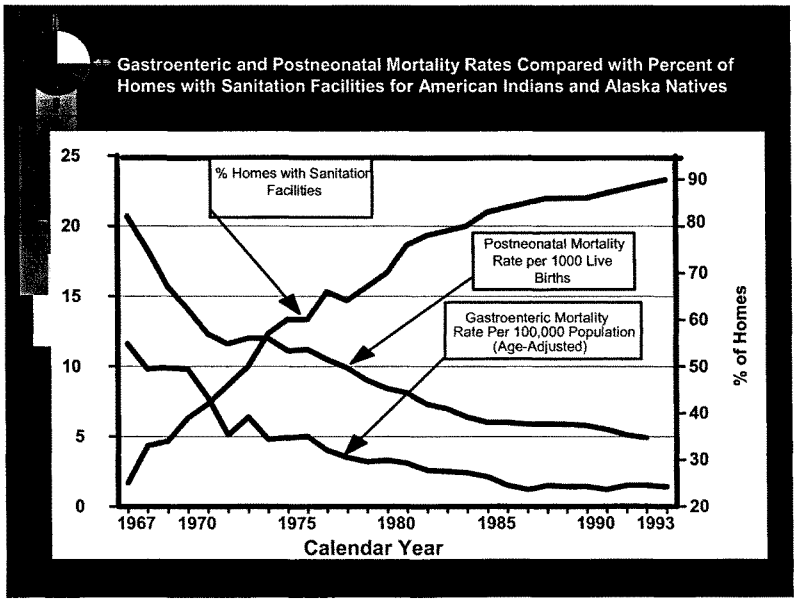
I am accompanied by Chief Andrew Jimmie of the Minto Traditional Council, who appears this morning in his capacity as Vice-Chair of the Alaska Native Health Board. Chief Jimmie also serves as President of the Tanana Chiefs Conference Regional Health Board, and recently received the prestigious Alaska Federation of Natives Health Award.

At the invitation of the Committees, I would like to discuss ANTHC's statewide sanitation and health facilities construction program, carried out in conjunction with the tribal health providers throughout the State, , and the vital role of this program in disease prevention and health promotion. Through sharing our experiences in Alaska, I hope to clearly portray the challenges presented by unmet sanitation and health facility needs in American Indian and Alaska Native communities nationwide.

Sanitation Facilities Construction Program

Over the last 40 years, the Indian Health Service (IHS) Sanitation Facilities Program has been remarkably successful. I am pleased to have had the opportunity to be a part of that program since 1980. I would like to personally thank the Committees for their foresight in establishing this proactive approach to public health improvement – sanitation facilities construction is first and foremost a health promotion/disease prevention program.

Water and Sanitation for Health Project studies indicate that child mortality rates are reduced as much as 82 percent by improving water supply and sanitation. IHS statistics present similar results. Figure 1 presents a stark graphic representation of the converse relationship between the percentage of American Indian/Alaska Native (AI/AN) homes with piped water and sewer and commensurate AI/AN gastroenteric and postneonatal mortality rates: reductions in comparison to the percent of AI/AN owned homes with piped water and sewer services.



As the percent of homes with sanitation facilities increases, post neonatal mortality rates and gastroenteric mortality rates decrease.

Table 1 presents the Alaska component of the national AI/AN unmet sanitation needs as reported by the Indian Health Service (IHS) Sanitation Deficiency System for fiscal year 2003.

Table 1.
National and Alaska Unmet Sanitation Needs for FY 2003

Category	Unmet Need
National Total	$1,593,529,976
Alaska Component	$637,262,519

Table 2 further illustrates the extent of the unmet needs in Indian Country by presenting the percentage of various categories of homes in the United States that do not have potable water in the home. The national AI/AN rate is more than 7 times the "All U.S." rate for homes that do not have potable water. The 25% of Navajo and 38% of Alaska Native homes without potable water are even higher.

Table 2.
Percentage of Various Categories of Homes without Potable Water

Categories of Home	Percentage of Homes without Potable Water
All U.S. Homes	1%
All American Indian/Alaska Native Homes (AI/AN)	7.5%
Navajo Reservation Homes	25%
Alaska Native Homes	38%

Alaska Native's have the highest percentage of homes without potable water in the home and experience the greatest discrepancy between all U.S. homes of which only 1% do not have potable water in the home.

The sanitation facilities construction program is a cornerstone in the foundation of today's Indian Health Network. Much has been accomplished, and much remains to be done. **Continued authorization of sanitation and facility construction and increased flexibility in the means by which Tribes may carry out this program is essential. Current funding levels are not nearly sufficient to make meaningful progress towards solving the unmet sanitation needs of American Indians and Alaska Natives. Nor, does current law permit the IHS and Tribes to maximize the limited resources that are available.** At the current funding level the Indian health system unmet need is increasing annually at a rate $50 million faster than construction. And just as disturbingly, the "All AI/AN Homes" percentage of homes without potable water presented in Table 2 has remained at 7.5% for the last six years.

Third World Sanitation in 21st Century Alaska

Rural Alaska has many unique conditions that magnify the challenges faced throughout Indian communities in the provision of a safe water supply and sanitary waste disposal. Vast distances, isolated and remote locations accessible only by air or water, and extreme temperatures are just a few of the factors impacting the provision of sanitation facilities to Alaska Natives. Even today over thirty percent of Alaska Native homes still lack piped water and sewer facilities. And in far too many Alaska Native communities, residents still have no choice but to shoulder the daily responsibility of hand-carrying the family drinking water supply into their homes, as well as hand-carrying the family's wastewater and human waste back out again.

In Alaska the Sanitation Facilities Construction program primary focus is on protecting the public health. But given the large unmet need, other goals have been integrated into the program to maximize its benefits for Alaska Natives, including:

- Promoting healthy lifestyles;
- Building basic community infrastructure;
- Providing local jobs and job training; and
- Promoting economic growth

Many challenges lay ahead. Of great concern to Alaska is the impact of changes to federal environmental regulations. Increasingly complex water quality and treatment regulations are causing huge increases in capital construction and system operating costs. Between 1993 and 2006 at least 13 federal drinking water related rules have been implemented or are scheduled for implementation. Examples include:

- The Lead and Copper Rule
- The Interim Enhanced Surface Water Rule
- The Arsenic Rule
- The Disinfection/Disinfection By-Products Rule
- The Filter Backwash Recycling Rule

Each regulation has an associated capital and operating cost increase. Some have even required that entire water treatment facilities be replaced to meet new operating criteria. While Alaska's goal is clean water that meets national standards, we need a common sense "first things first" approach as we seek to put basic infrastructure in place. On-the-ground realities of situations such as ours must be factored into the implementation of these new regulations to avoid doing unwarranted harm to the compelling national policy goals underlying the IHS SDS system.

Alaska Native Health Facilities Overview

The Native health network in Alaska is comprised of the Alaska Native Medical Center, 6 Regional Hospitals, and some 180 sub-regional and community health aide clinics. The current documented unmet need for Alaska Native health facilities exceeds $630 million. The oldest hospital in the network has been in operation in Nome since 1948. It has been on an IHS priority list for replacement along with the regional hospital in Barrow for 15 years. The St. Paul Clinic has been in operation since 1926 and is now in the process of being replaced by the IHS.

Given the remote nature of our communities, the village clinics form the foundation of our health care system. A 2001 clinic facilities status survey found that only 17% of reporting facilities were judged as adequate. Many lack even the basics of running water. Imagine receiving medical care in a facility where medical professionals cannot practice the fundamentals of good hygiene. The Yukon-Kuskokwim Health Corporation reported in 2003 that only 51% of their 47 clinics had piped water and sewer services. They also indicated that 34% rely on honey buckets and outhouses for waste disposal. The Lime Village clinic outhouse pictured above is not unique.

Key Sanitation and Facilities Provisions of H.R. 2440, Compared to S. 556

It has been over 25 years since the original enactment of the Indian Health Care Improvement Act. Now, this latest effort at reauthorization, in which these Committees have cooperatively taken a leadership role, truly proves how much has been accomplished. Under the leadership of the National Steering Committee, including tribal leaders from every Area and representatives of the IHS and national Indian organizations, the 1999 National Steering Committee (NSC) draft, largely embodied in S. 556, has been improved even further as reflected in H.R. 2440. Although there was significant consultation prior to completion of the 1999 NSC Draft in the three years that have passed, tribal leaders have had an opportunity to reflect more on the choices and to consider the initial comments of the Department of Health and Human Service to S. 212 (the predecessor to S. 556). The product of this additional work is found in H.R. 2440.

I am pleased to testify this morning that from a sanitation and facilities operations perspective, I wholeheartedly recommend that the Senate Committee substitute the Title III sanitation and facilities provisions of H.R. 2440 for the parallel provisions of S. 556, and that both Committees take early action to assure passage of the reauthorization bill.

Passage of the Indian Health Care Improvement Act reauthorization is urgently needed in order to achieve the efficiencies and to make available the opportunities provided for in the two bills. The reauthorization bills fundamentally enhance the ability of the Indian Health Service and Tribes to deliver critically needed services, as well as clarify operational authorities and requirements in the management of facility programs. Language improvements in Title III of H.R. 2440 build on the original work of the NSC and the Senate.

I would like to highlight a few of the important provisions of Title III and comment on some of the differences between the Senate and House bills.

- **Sec. 301(a)(2). Prerequisites for Expenditure** better meet the needs of the Secretary by more clearly establishing the requirements and purpose of accreditation of health care facilities while maintaining the flexibility to the facility manager as to selection of the accrediting body. In response to concerns expressed by the Administration, H.R. 2440 specifies that the construction standards be ones that will satisfy the requirements of the Medicare, Medicaid and SCHIP programs under the Social Security Act.

- **Sec. 301(c). Health Care Facilities Priority System** provides for the establishment of Service Area priorities in addition to more comprehensive National priorities. *See* H.R. 2440 section 301(c)(2)(B)(I). This promotes and provides Tribes more opportunity to seek non-federal funding for high priority health facility projects within Service Areas. It also expands the list of prioritized facilities to include all staff quarters' developments and hostels to provide a more accurate report.

  H.R. 2440 differs in one other important respect from S. 556. S. 556 requires that "life expectancy" must be treated as a factor in giving additional priority for facilities. S. 556 section 301(c)(1)(B). H.R. 2440 does not include this limiting priority. H.R. 2440 section 301(c)(1)(A). Instead, like the 1999 NSC Draft, the factors for determining priorities are not predetermined and will be developed through negotiated rulemaking with Indian Tribes and tribal organizations. I urge the Committee to consider adopting the a similar approach. The range of factors that may be relevant is significant and each possible factor deserves the close technical examination that rulemaking is well-suited to accomplish.

- **Sec. 301(d). Initial Report of Facility Need.** The Departent of Health and Human Services criticized this provision of S. 212 (also found in S. 556) and the 1999 NSC Draft, both of which require an annual report by the Secretary listing all facility needs of the IHS, Tribes, tribal organizations, and urban Indian organizations, including the need for renovation and expansion. The Secretary expressed concern about the complexity and cost of preparing such a report. The NSC responded by asking that H.R. 2440 require that the initial report be developed by the General Accounting Office and that in subsequent years updates be done by the Comptroller General and Secretary in consultation with Indian Tribes, tribal organizations and urban Indian organizations. This is a fair compromise that will still achieve the important objective of providing to the Congress a complete picture of the unmet need for new facilities and for improvements and expansion.

- **Sec. 302(b). Facilities and Services** eliminates the prohibition of the use of P.L. 86-121 sanitation facilities construction funds for HUD funded homes. In its place it makes HUD funded homes eligible, but at a lower priority than other existing and new Indian homes. *See* H.R. 2440 section 302(c)(3)(A) and (B). Once again, this seems a fair compromise position between current law and S. 556, which prohibit the use of funds for HUD funded homes and the advocacy position of the National American Indian Housing Counsel (NAIHC), which seeks equal status for HUD funded homes with all other homes.

  Currently the Indian Health Service (IHS) maintains a central database that tracks and reports unmet sanitation needs in Indian country. This program is currently authorized to provide sanitation facilities for other than HUD funded Indian homes only. At its current funding levels, some 900 eligible Indian owned homes remain unserved each year. As HUD funded homes are not eligible for assistance under this program, this need is not tracked, making current reports to Congress incomplete. By authorizing the use of P.L. 86-121 dollars for HUD funded Indian owned homes at a lower priority than those currently authorized, a centralized national database of unmet sanitation need can be readily operated by the IHS with existing resources. Existing eligible housing remains the top priority for service, and tribally designated housing authorities are encouraged to work cooperatively in the orderly planning and construction of basic community infrastructure.

- **Sec. 302(j). Definitions** defines the term "sanitation facilities" and then uses the term in place of a descriptive phrase used throughout the S.556. This adjustment makes the law much easier to read and understand.

- **Sec 303(b). Labor Standards** establishes a prevailing wage rate process consistent with NAHSDA, enabling Tribes to administer their programs more efficiently. Nationally Indian housing programs are funded at a rate some ten times greater than that of sanitation facilities construction. Tribal construction process and practice is typically centered around and based on the requirements of the NAHSDA program due to its size. H.R. 2440 would enable Tribes to realize economies of scale not otherwise possible in the administration of its construction projects.

  In Alaska, a tribally managed prevailing wage rate process would be more responsive to local needs and based on information collected in tribal communities. The last applicable wage survey was conducted in 1996, published in 1999, and did not include interior and northern Alaska where most of our Tribes are located.

- **Sec. 308. Leasing.** The new language in both bills regarding treatment of leases by the Secretary of Tribal facilities as operating leases for the purposes of scoring under the Budget Enforcement Act provides an important new opportunity for Tribes to participate in funding the facility needs of their health programs.

- **Sec. 310. Health Care Facilities Loan Fund** provides a similar opportunity to increase the options for addressing the devastating underfunding of Indian health facilities.

- **Sec. 311(a). Indian Health Service/Tribal Facilities Joint Venture Program** establishes a demonstration project process under which eligible Tribes may expend non-federal funding to construct a new facility and the IHS provides the funding necessary to staff and operate that facility. By broadening the window of eligibility for Tribes to participate beyond the actual period of facility construction, the reauthorization bill allows Tribes the opportunity to make sound financial commitments without increasing the cost of IHS participation, since a commitment by the IHS to participate prior to the irrevocable commitment of substantial funding by a Tribe is now possible.

ANTHC Organizational Background

ANTHC was formed in December 1997 to assume all non-residual IHS statewide services. It is the first tribal Area Office in the IHS system. ANTHC's board is representative of all Tribes in Alaska. It is one of the twenty co-signers of the Alaska Tribal Health Compact, the largest self-governance compact with the IHS.

ANTHC's mission is to provide the highest quality health services for all Alaska Natives.

Based in Anchorage, ANTHC offers a wide-range a range of services across Alaska. ANTHC co-manages the Alaska Native Medical Center, the tertiary care hospital for the Alaska Native health system. In support of its own programs and those of tribal health programs throughout Alaska, ANTHC provides centralized purchasing of medical supplies and pharmaceuticals, provision of specialty medical care services, centralized professional recruiting and credentials verifications, technology development, health research, and the AFHCAN project.

Working in with Native communities and organizations on the local, state, and federal levels, DEHE plans, designs, and constructs sanitation facilities, bringing safe water and wastewater disposal improvements to thousands of Native-owned homes. In 2002, 3,660 Native homes were served. This year, DEHE provided sanitation facility improvements in 92 Alaska communities.

In 2002, DEHE administered 36 maintenance and improvement projects for health care facilities managed by 11 tribal health organizations. In addition, through a partnership with the Denali Commission, DEHE manages a program that plans, designs, builds, and renovates health clinics. This year the Division completed clinic projects in 12 communities and started projects in 44 others.

In support of these sanitation and facility construction programs, ANTHC DEHE offers other tribal health programs access to a design and engineering group, construction project management, and the Alaska Utility Supply Center. The Center offers village operators a single source for material and equipment for utility systems, saving operation downtime and providing bulk purchasing economies. The supply center currently has 115 active community accounts.

Conclusion

In conclusion, I would again thank Chairman Campbell, Chairman Pombo, and the respective Committee members for this opportunity to share an Alaskan perspective from "the trenches." On behalf of myself, my Division, and the Alaska Native Tribal Health Consortium, I look forward to continuing to work in partnership with the Congress and the Indian Health Service to build healthy and safe American Indian and Alaska Native homes and communities. Thank you, I would be happy to answer any question you may have.

ANTHC DEHE projects offer value in fundamental ways:
they provide basic sanitation and health services for Alaska Natives,
advance community economic development, and
help improve the present and strengthen the future of Alaska Native people.

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August 8, 2003

The Honorable Ben Nighthorse Campbell
U.S. Senate
Committee on Indian Affairs
Washington, D.C. 20510-6450

Dear Senator Campbell:

Re: Responses to Questions Regarding the *"Indian Health Care Improvement Act Amendments of 2003"*

Thank you for your letter dated July 24, 2003 regarding my testimony before the joint hearing with the Senate Committee on Indian Affairs and the House Committee on Resources, which occurred on July 16, 2003. I certainly appreciate the opportunity to address these committees on issues critical to the success of our program in Alaska and which affect services to all American Indian and Alaska Native people.

Enclosed are the responses to questions from the Senate Committee on Indian Affairs. We have also responded to questions from Congressman Pombo. A copy of this response is enclosed at your request.

Please let me know if we can be of further assistance. Thank you for your concern on these important issues.

Sincerely,

for Steven M. Weaver, P.E.
Sr. Director
Division of Environmental
Health and Engineering

Enclosures

INTRODUCTION:

The Indian Health Service (IHS) FY 2003 Sanitation Deficiency System identifies the total unmet need to provide safe drinking water and adequate waste disposal facilities for American Indian/Alaska Natives as $1.594 billion. Sanitation deficiencies for NAHASDA homes are not included in this database. As NAHASDA homes represent a significant part of American Indian/Alaska Native housing units, the total sanitation facilities unmet need for Indian Country would be difficult to determine.

BACKGROUND:

The Alaska Native Tribal Health Consortium (ANTHC) assumed responsibility for the IHS Alaska Area Sanitation Facilities Construction Program in October 1998. The historical collaboration of HUD, IHS and BIA to provide adequate sanitation facilities through a tri-party agreement has been replaced by NAHASDA. More than 80 new tribal housing entities were created in Alaska and have been for the most part independently providing sanitation facilities for their newly constructed homes. Given the high cost of arctic utilities infrastructure, the lack of consideration for utility infrastructure development, and in the interest of providing more new homes, many of these entities have elected to construct homes without adequate water supply and sanitary waste disposal facilities.

The ANTHC, IHS, State of Alaska and other partners recognize that pooled resources create a consistent revenue stream and increase system sustainability. Eligibility for access to supplemental water and sewer facility funding from the State of Alaska is now available on a competitive basis for Regional Housing Authorities and Tribally Designated Housing Entities who collaboratively plan new housing developments with the communities in which these homes are to be located. Planning and development is becoming more community and region-based as opposed to an agency program based approach. This concept maximizes community involvement, promotes community ownership of constructed facilities, typically reduces unit capital construction costs and assures a more sustainable outcome for the long term. This holistic approach is resulting in more multi-funding source projects, rather than the historical piecemeal approach of the past where each agency funded multiple independent projects in the absence of knowledge of or coordination with other funding sources.

QUESTION #1A: *In Alaska, how are you using NAHASDA funds to address the need for sanitation facilities?*

RESPONSE

Most Regional Housing Authorities and Tribally Designated Housing Entities in Alaska independently provide their own sanitation facilities as part of housing construction projects. Due to the remote location of communities and the harsh arctic environment of Alaska the cost of arctic utilities is high. There is also a large unmet need for adequate housing and there is great pressure to construct as many homes as possible.

Consequently, many new homes are being constructed without adequate provisions for safe water supply and sanitary waste disposal.

As mentioned in my testimony, the IHS sanitation facilities construction program is under funded to serve currently eligible homes. To unilaterally expand program eligibility to include HUD funded housing sends a message to HUD and Tribally Designated Housing Entities that funding the sanitation facilities for their homes is not their primary responsibility and, as NAHSDA is the vastly larger of the two programs, risks overwhelming the current IHS process. In order to not overwhelm the current IHS system while working toward eliminating the backlog of unmet need, HUD financed homes should receive prioritized access to IHS funding but at a level lower in priority than that of other Indian housing. This prioritized access creates a cooperative environment employing collaborative strategies that leverage funding while preserving the process.

QUESTION #1B: *How are IHS funds currently used in Alaska to address sanitation facilities construction?*

RESPONSE

The IHS sanitation facilities construction program is first and foremost a health promotion disease prevention program. Long-term public health improvements require the successful operation of sustainable water supply and sewage disposal facilities with the program deliverable being healthy and safe Native communities. To best achieve this outcome, a holistic approach to the planning and development of sanitation infrastructure is required.

The ANTHC has continued the partnership with the State of Alaska Village Safe Water (VSW) Program originally forged by the IHS. The ANTHC and VSW collaboratively rate and rank rural Alaska sanitation facilities construction project proposals using IHS Sanitation Deficiency System and State Capital Improvement Project criteria. Projects are jointly funded on a community basis to maximize economy of scale advantages and minimize project mobilization/demobilization expenses. Design criteria and procurement processes are shared to reduce administrative cost. Local resident construction skills training is encouraged and has been formalized on the projects to increase local economic gain from the project construction and to improve the skill set within the community to enhance the long term community capacity to own and operate the constructed sanitation facilities.

QUESTION 1C: *One proposal is to allow IHS funds to be used for constructing sanitation facilities for new HUD homes, but at a lower priority than other Indian homes. This proposal might build more houses, by freeing up more NAHASDA funds solely for housing, but could also create more sanitation needs. Explain how this proposal will resolve the unmet needs?*

RESPONSE

The current IHS sanitation deficiency system of unmet needs does not include HUD financed housing unmet needs because they are not eligible for IHS funding. This prohibition has created a two track mindset that starts at the point of planning and continues through construction. It creates pockets of development within the community and leaves the tribal utility with an unfunded mandate to operate and maintain the outcome. In summary, keeping the IHS and HUD programs separate does not allow the IHS and the Tribes to maximize their resources to resolve the unmet sanitation needs.

We propose a change that would allow NAHASDA housing to be eligible for IHS sanitation funding, but at a lower level priority than currently eligible Indian homes. This change would promote collaborative community-based solutions rather than isolated agency program criteria for sanitation needs. Native communities are composed of housing from many sources. All of that housing needs safe water and sanitary waste disposal to affect community public health. It also provides tribal program managers more flexibility in the operation of programs in the event of future shifts in program funding.

As a tribal program manager with 20 years experience, I do not believe that making IHS funds available to serve NAHASDA housing would significantly increase the number of NAHASDA homes being built unless the current IHS project funding level was increased at least fifty percent. The NAHASDA program is a much larger program than the IHS sanitation facilities construction program. At current funding levels I am told that IHS would need an annual increase of some $20 million in project funds just to meet the needs of currently eligible Indian homes. In addition to increases in project funding, program staffing would also have to be increased commensurate with project workload increases.

I believe the NAHASDA program should retain the primary responsibility for providing first service sanitation facilities for NAHASDA housing. I believe that providing the potential for funding through the IHS sanitation facilities construction program will promote joint planning and development practices that will greatly benefit communities in the long-term operation of their systems. Joint planning and use of common procedures will reduce tribal administrative and management expenses in both the construction and operation of sanitation facilities. A single database maintained by IHS to track all sanitation unmet need in Indian Country could also promote more cost effective regional solutions to sanitation deficiencies once the real patterns and trends are inventoried and analyzed.

A large part of the IHS sanitation facilities construction program is upgrading key facilities to meet new water quality and waste disposal statutes and regulations, as well as replacing aging core facilities at the end of their useful life. It would be reasonable for NAHASDA housing to be eligible for inclusion in such improvement projects which are currently being funded by the IHS.

QUESTION #2: *As a hands-on facilities engineer person, can you provide our Committee with some suggestions for more creative ways to address financing and construction of more sanitation facilities?*

RESPONSE

Last year ANTHC prepared a summary report on suggestions to improve the Alaska sanitation facilities construction program. It was transmitted to HHS Secretary Thompson by the Yukon Kuskokwim Health Corporation following his visit to Alaska. Four of the five recommendations in the report entitled: "3rd World Sanitation in 21st Century Alaska," are suggestions for more creative ways to finance the construction and operation of sanitation facilities.

Relevant recommendation are summarized below:

(1) Promote other program funding agency (USEPA & USDA RD) utilization of IHS authorities for 100 percent advance payment of project funding and the earning of interest on unexpended project balances to allow ANTHC to expand its sanitation facilities program within existing funding levels.
(2) Promote small community system compliance waivers/implementation delays for new USEPA water quality and treatment enhancement requirements. While Alaska's goal is clean water that meets national standards, we need a common sense "first things first" approach as we seek to put basic infrastructure in place.
(3) Implement a local utility matching pilot program that will extend the operating life of existing utility infrastructure and allow increased focus on the construction of new services.
(4) Provide for the option of a lifecycle cost based project planning/award process that provides utility operating credit for the community when utility systems are selected that have a lesser overall construction and operating cost. For example a haul system in lieu of an arctic circulating piped water/vacuum sewer system.

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August 1, 2003

The Honorable Richard Pombo
U.S. House of Representatives
Committee on Resources
Washington, D.C. 20515

Dear Congressman Pombo:

Re: Responses to Questions Regarding the *"Indian Health Care Improvement Act Amendments of 2003"*

Thank you for your letter dated July 24, 2003 regarding my testimony before the joint hearing with the Senate Committee on Indian Affairs and the House Committee on Resources, which occurred on July 16, 2003. I certainly appreciate the opportunity to address these committees on issues critical to the success of our program in Alaska and which affect services to all American Indian and Alaska Native people.

Enclosed are the responses to questions from the House Committee on Resources. We also received a letter from Senator Campbell regarding questions from the Senate Committee on Indian Affairs. We are working on this response, which is due no later than August 8, 2003. Senator Campbell requested a copy of our response to you in addition to responses to his questions.

Please let me know if we can be of further assistance. Thank you for your concern on these important issues.

Sincerely,

for Steven M. Weaver, P.E.
Sr. Director
Division of Environmental
Health and Engineering

Enclosure

Questions for panelists of the Joint Hearing of the Senate Indian Affairs Committee and the House Resources Committee on S.556 and H.R. 2440, the Indian Health Care Improvement Act Reauthorization of FY 2003

Panel II Questions

From Chairman Pombo to Mr. Weaver:

1. *You stated in your testimony that current funding levels are not nearly sufficient to make meaningful progress towards solving the unmet sanitation needs of American Indians and Alaska Natives. H.R. 2691, the House Interior Appropriations bill, has specifically included Committee language which states that IHS sanitation funds should not be used to provide sanitation facilities for new homes funded by the housing programs of the Department of Housing and Urban Development.*

   How does this affect the ability to permit the IHS and Tribes to maximize their resources to resolve the unmet needs of sanitation and facilities in Indian county?

RESPONSE:

The House Interior Appropriations bill, H.R. 2691, states that IHS sanitation funds should not be used to provide sanitation facilities for new homes funded by Department of Housing and Urban Development housing programs. In a time when current funding levels are not sufficient to make meaningful progress toward solving the unmet sanitation needs of American Indians and Alaska Natives, keeping the IHS and HUD programs separate begs the question of how these programmatic restrictions are affecting our ability to meet sanitation needs.

Keeping the IHS and HUD programs separate by unilateral prohibition simplifies program implementation processes for the agencies; however, this simplification also removes flexibility at the tribal program manager level. Indian communities are comprised of both HUD financed and non-HUD financed housing. Water and sewer systems need to be planned and developed to serve entire communities, not subsets of housing types. Combining infrastructure construction projects achieves larger scopes of work and economies of scale. Incorporating Tribally Designated Housing Entities into the community and regional planning process creates economies of scale in both the construction and operation of facilities.

The current IHS sanitation deficiency system does not include HUD financed housing unmet needs because they are not eligible for IHS funding. This prohibition has created a two track mindset that starts at the point of planning and continues through construction. It creates pockets of development within the community and leaves the tribal utility with an unfunded mandate to operate and maintain the outcome. In summary, keeping the IHS and HUD programs separate does not allow the IHS and the Tribes to maximize their resources to resolve the unmet sanitation needs in Indian Country.

By creating prioritized access to IHS sanitation facilities construction funds for HUD financed housing, a management tool can be developed for use by local tribal leaders that is not currently

available and will help the IHS and Tribes to maximize resources. Another benefit of allowing coordination between the IHS and HUD programs is that the ability to fund community system improvements following a first service becomes potentially available. It is clear that agencies that fund housing also have a primary responsibility to fund sanitation facilities at the time housing is constructed.

2. *We have heard repeatedly that diabetes, alcoholism, accidents, behavioral health, suicides and homicides are on the rise in Indian country, and that access to health care is critical for the prevention and treatment of these problems. I applaud the efforts of tribal health care providers in implementing educational and prevention programs for their patients in trying to treat these issues. What can this Committee and Congress do besides increasing Appropriations for prevention programs and authorizing legislation to correct these disparities in Indian country?*

RESPONSE:

Well thought out, planned and delivered prevention programs have proven to save direct health care funds. For example, as a result of increased funds and program emphasis on injury prevention, injury hospitalizations across Indian country were reduced by 68 percent between 1987 and 1997, resulting in substantial savings in direct patient care. Additional funding for preventive public health activities in the areas of diabetes, substance abuse, behavioral health and injury prevention including suicide and homicide would further reduce the cost of direct patient care and the burdens placed on the health care system.

In Alaska, deaths due to injury in the Alaska Native population are decreasing. The decrease is due to injury prevention activities and improved access to primary health care through the Community Health Aide Program (CHAP). The CHAP program increases access to care and early intervention resulting in health status improvement. Alaska is working to expand the CHAP model by piloting like programs in behavioral and dental health. The extension of this critical program authority to each recognized tribe through the passage of the Indian Health Care Improvement Act Reauthorization would begin to address the access to health care need in Indian country.

Additional actions and initiatives:

- Funding available to address injury prevention initiatives are appropriated through several federal agencies (CDC, HRSA, DOT-NHTSA, FEMA, CPSC, NIH, SAMSA); tribes need to access these sources of funds as states and other organizations currently do. However, tribes are faced with institutional and administrative barriers that put them at a distinct competitive disadvantage in accessing funding: tribes are legislatively not eligible applicants in some cases (HRSA funding); are at a distinct competitive disadvantage because they have to compete directly with states (CDC); and in most cases agencies do not have Indian specific initiatives established. Congressional assistance in removing barriers and increasing Tribes access to federal funds is essential.

- A proportional set-aside for funding to tribes by funding agencies and/or language that enables tribes to be eligible and competitive for funding would help overcome barriers Tribes face in accessing federal funds.

From Rep. Don Young to Mr. Weaver:

1. *It is my understanding that in Alaska, the Alaska State Housing Authority has expressed interest in utilizing IHS sanitation funds to help eliminate the backlog of sewer and water facilities in Alaska. What recommendations would you make to utilize both IHS and HUD funds for sanitation and facilities construction to help eliminate this backlog, not only in Alaska, but also in Indian country?*

RESPONSE:

Before offering my recommendations about using both IHS and HUD funds to eliminate the backlog of unmet sanitation facilities needs in Alaska and Indian Country, I would like to briefly discuss the current IHS program and the joint planning situation in Alaska as it applies to these recommendations.

The IHS sanitation facilities construction program is first and foremost a health promotion disease prevention program. Long-term public health improvements require the sustained successful operation of water supply and sewage disposal facilities with the program deliverable ultimately being healthy and safe Native communities. To best achieve healthy and safe Native communities, a holistic approach to the planning and development of sanitation infrastructure is required.

The implementation of the Native American Housing Assistance Self-Determination Act (NAHSDA) has virtually eliminated joint planning and water/sewer construction efforts. I believe the unilateral statutory exclusion that derived from NAHSDA helps create a "more comfortable" environment for agencies to "silo" their sanitation facilities development efforts. However, a cooperative environment that promotes the commitment of agencies and tribes to identify unmet need and develop successful collaborative strategies to meet those needs is required to eliminate the backlog of sanitation facility needs in Alaska and Indian Country.

In Alaska, agreements are being forged among the Tribes, federal and state agencies, and the ANTHC that promote joint community wide sanitation facilities planning efforts. The objective of these agreements is to reduce unit construction and operating costs for water and sewer systems in order to better develop levels of service that are adequate to protect the public health and be sustainable for the long term. The State of Alaska is facilitating this process by making sanitation facilities construction funding available to housing authorities on a prioritized competitive basis, thus promoting community and regional planning and development efforts to help ensure higher scores on their respective projects.

As mentioned in my testimony, the IHS sanitation facilities construction program is under funded to serve currently eligible homes. To unilaterally expand program eligibility to include HUD funded housing sends a message to HUD and Tribally Designated Housing Entities that

funding the sanitation facilities for their homes is not their primary responsibility and, as NAHSDA is the vastly larger of the two programs, risks overwhelming the current IHS process. In order to not overwhelm the current IHS system while working toward eliminating the backlog of unmet need, HUD financed homes should receive prioritized access to IHS funding but at a level lower than that of other Indian housing. This prioritized access creates a cooperative environment employing collaborative strategies that leverage potential while preserving the process.

CITIZEN POTAWATOMI NATION

July 14, 2003

Honorable Ben Nighthorse Campbell, Chair
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

via: testimony@indian.senate.gov
john_tahsuda@indian.senate.gov

Re: Indian Health Care Improvement Act (IHCIA). Hearing scheduled for July 16, 2003

Dear Chairman Campbell:

On behalf of the Citizen Potawatomi Nation, I would like to take this opportunity to commend you and the National Steering Committee (NSC) on the hard work that has been put forth towards the Reauthorization of the IHCIA. The purpose for this letter is to provide comments regarding compromise language in Section 512.

As background information, the Citizen Potawatomi Nation has been participating with other tribes, urban providers and the IHS in meetings over the past three years regarding this issue. As you are aware, this law provides detailed framework and funding authorization for all Indian health programs throughout the United States. While a number of issues have been painstakingly negotiated, one shortcoming remains which is of utmost concern to the Citizen Potawatomi Nation: Section 512 that addresses the status of the Oklahoma City Urban Indian Clinic. Section 512 states: "Notwithstanding any other provision of law, the Oklahoma City Clinic demonstration project and the Tulsa Clinic demonstration project shall be treated as service units in the allocation of resources and coordination of care and *shall not be subject to the provisions of the Indian Self-Determination Act for the term of such projects*...(emphasis added).

In the early 1990's, the Oklahoma City Area Office of the Indian Health Service unilaterally transferred millions of direct service resources to the Oklahoma City Urban Project Buy Indian Contract when the tribal Self-Governance activities in the Shawnee Service Unit began. This action deliberately denied the five indigenous Shawnee Service Unit Tribes access to these resources. In effect, the five Shawnee Service Unit Tribes gave up funding to provide for all urban Indians in Oklahoma City, a classic example of "robbing Peter to pay Paul."

In addition to denying these resources to the five tribes, the action provided justification for denying more funding to the five Shawnee area tribes by providing an excuse for the continued presence of additional IHS staff in the Oklahoma City Area Office to provide technical support for the Urban Project.

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This chain of events is very damaging to the Citizen Potawatomi Nation and prevents a government-to-government relationship for the provision of health services which is the basis for health service dollars. Furthermore, the Citizen Potawatomi Nation Clinic and three other tribal clinics continue to provide health services to Indian people living within the Oklahoma City area without funding for the additional service population. As our efforts continue to improve the quality of our services, more Oklahoma City Indians will come. We won't have the funding to care for them because the Oklahoma City Urban Clinic is not contractible, compactable, or accountable to the Tribes. It is an abrogation of the concept of Indian self-determination and contrary to the intent of Congress in all prior health funding.

Section 512, as currently drafted, would give permanent status to the Oklahoma City and Tulsa Urban clinics without being held subject to the Indian Self Determination Education and Assistance Act (ISDEAA). This is a position that the Citizen Potawatomi Nation has vehemently opposed over the past three years. The NSC held a meeting December 12th-13th, 2002, in Rockville, Maryland, in which a compromise language for Section 512 was proposed:

> (a)(1) Notwithstanding any other provisions of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs within the Service's direct care program, continue to be treated as service units in the allocation of resources and coordination of care, and shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act provided the programs shall not be divisible, absent unanimous consent of the surrounding tribes.

The Nation is willing to compromise and support the language as drafted. The Citizen Potawatomi Nation does not believe that these urban programs should be granted permanent status with funding like a service unit. However, the Tribe will support this "special status" IF it is subject to the Indian Self-Determination and Education Assistance Act, as is proposed above.

Thank you for your attention on this matter. The Citizen Potawatomi Nation looks forward to working together to form a more positive outcome for the Indian people in Oklahoma. If you should have any questions, please feel free to contact Rhonda Butcher, Citizen Potawatomi Nation Self-Governance Director, at (405-275-3121.

Sincerely,
CITIZEN POTAWATOMI NATION

Linda K. Capps,
Vice-Chairman

cc: jpetherick@nihb.org

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Indian-Affairs, Testimony (Indian Affairs)

From: Carolyn Romberg [carolynr@astribe.com]
Sent: Tuesday, July 15, 2003 12:24 PM
To: Indian-Affairs, Testimony (Indian Affairs); Tahsuda, John (Indian Affairs)
Cc: J. T. Petherick (E-mail)
Subject: IHCIA Section 512, Committe hearing

Honorable Ben Nighthorse Campbell, Chair
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

via: testimony@indian.senate.gov
john_tahsuda@indian.senate.gov

Re: Indian Health Care Improvement Act (IHCIA). Hearing scheduled for July 16, 2003

Dear Chairman Campbell:

I have continued to voice the opinion of the Absentee Shawnee Tribe and other tribes in this area for several years regarding this issue, and will continue to voice my concerns with the Senate's current version of Section 512. This section if left as currently drafted in the Senate side, gives the status of a tribe to an urban 501 (c) 3 entity, that has a directorship that lasts for the eariler of the resignation or death of the director.

No other entities like these will be in existence, except for these two, if the language as is currently drafted in the senate version continues to push through the halls of Congress. I plead with you NOT to abrogate the rights of the Absentee Shawnee Tribe by legislation that infringes on our sovereign rights.

Make both of the urban clinics subject to the Indian Self Determination Act, and make them follow the rules that all tribes must follow in providing health care to native americans. Please do not set the precedent, that can not be undone by our grandchildren and great-grandchildren. Please adopt the language as it currently appears in the House of Representatives Version of Section 512.

Sincerely,

James Lee Edwards, Governor of the Absentee Shawnee Tribe

and

Carolyn Romberg, Health Director AST Health Programs
Absentee Shawnee Tribe of Oklahoma
2025 S. Gordon Cooper Drive
Shawnee, OK 74801

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National Indian Youth Council, Inc.
318 Elm Street S.E.
Albuquerque, NM 87102

July 21, 2003

Rhonda

The Honorable Ben Nighthorse Campbell, Chairman
Senate Indian Affairs Committee
United States Senate
838 Hart Office Building
Washington, DC 20510

The Honorable Richard Pombo, Chairman
House Resource Committee
U.S. House of Representatives
1324 Longworth House Office Building
Washington, D. C. 20515-6201

Dear Senator Campbell and Representative Pombo:

On July 17, 2003 the Senate Indian Affairs Committee and the House Resources Committee held a joint hearing on the reauthorization of Public Law 94-437, the Indian Health Care Improvement Act. On behalf of the Albuquerque urban Indian community, I am submitting comments to be included in the recent hearing on Public Law 94-437. I request the attached document and its contents be part included as a part of the record in its entirety, including this letter.

Basically, the problems and issues in regards to urban Indian health care delivery services through the Indian Health Service is not adequately being addressed by all parties involved from the local Albuquerque HIS Service Unit level to the Washington, DC Indian Health Service office and much it is because of the lack of understanding of our situation. The urban Indian population, which continues to receive health care services from the Albuquerque Indian Health Service Hospital and Dental Clinic, is being ignored and left out of the consultation process of both the U. S. Department of Health and Human Services and the Indian Health Service. Consultations by the Indian Health Service occur only with tribal government leaders and operators of IHS recognized nonprofit organizations which delivery some health care services to the urban Indian population (and, in some cases, to non-Indians, such as the situation with the one in Albuquerque, i.e. First Nations Healthsource). Most of the Albuquerque urban Indian population still receives health care services from the Albuquerque Indian Health Service Hospital and Dental Clinic. It is this population that is forgotten in the consultation process, especially in discussions of IHS health care policy issues and funding priorities.

The reason for concern about consultation is that health care services are being reduced to the Albuquerque urban Indian population, because tribes or tribal governments are contracting the available Indian Health Service health care services, along with the

funding that goes with these services. Because of the lack of provisions in Public Law 94-437 regarding direct funding of existing Indian Health Service facilities for the urban Indian population, such as the Albuquerque Indian Health Service Hospital and Dental Clinic, health care services are being reduced drastically once tribes decide to contract these services under PL 93-638. According to the Albuquerque Indian Health Service, even though it justifies its budget with the urban Indian user numbers, the urban Indian community has no alternative, but to have services reduced to them, so that tribes can take all of the funds to set up their own community health care services.

To address the direct funding of the Albuquerque Indian Health Service Hospital and Dental Clinic, Albuquerque urban Indian representatives have requested inclusion of an amendment to PL 94-437. I would appreciate support for this amendment, so that the Albuquerque Indian Health Service can receive direct funding on behalf of the Albuquerque urban Indian community. Otherwise, any funding for the Albuquerque Indian Health Service Hospital and Dental Clinic would be diverted elsewhere, as in the case, recently, of the $1.0 million appropriated to the Albuquerque IHS Dental Clinic.

Thank you for allowing our input and your assistance in these matters.

Sincerely,

Norman Ration, Executive Director

Recommended New Language to be Inserted to the Indian Health Care Improvement Act Amendments of 2003

SECTION 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS AND EXISTING URBAN INDIAN HEALTH SERVICE FACILITIES.

Add a new section (c) with the following new language: "Notwithstanding any other provisions of law, the Albuquerque Area Indian Health Service Dental Clinic and Hospital, which now serve urban American Indians residing in the Albuquerque urban area, shall continue to serve urban Indians and be further designated, in addition to continuing to serve tribes, as a Service Unit in the allocation of additional resources and coordination of care for the Albuquerque urban Indian population and, as such, those resources specifically appropriated by the U. S. Congress and health care reserved for the urban Indian user population shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act and, futher, such designated urban Service Unit shall establish, with input by the Albuquerque grassroots urban Indian community, an urban Indian advisory group to further the consultation provisions of this Act

***Note:** Underscored portions of the above are new language to be added to Section 512 of the Act.

Written Comments Regarding the Reauthorization of Public Law 94-437, the Indian Health Care Improvement Act

Submitted by National Indian Youth Council on Behalf of the Albuquerque Urban Indian Community

July 21, 2003

American Indians, who have primarily lived on Indian Reservations, are migrating to the urban areas at an alarming rate. In 1980, the U. S. Census data indicated about half of the 1.4 million American Indians resided in urban areas. According to the 2000 U. S. Census data, over 70 percent of the American Indians now live in the urban areas. Much of this migration can be attributed to the lack of employment on Indian Reservations and federal policy, including work requirements of the Welfare Reform Act.

The Albuquerque, New Mexico area has a large urban Indian population of about 33,000 representing over 200 tribes. The largest tribal groups represented are the Navajos and Pueblos whose reservations are in close proximity to the Albuquerque urban area. Health care is available through the local Albuquerque Area Indian Health Service Hospital and Dental Clinic. First Nations Healthsource, a local nonprofit organization recognized by the Indian Health Service as an Indian health care provider under Title V of the Indian Health Care Improvement Act, also provides some health care services, including, beginning in 2002, a dental clinic. First Nations also provides health care services to non-Indians. Most of the urban Indians in the Albuquerque area utilize the Albuquerque Indian Health Service Hospital and Dental Clinic. About 85 percent of the users of the Albuquerque Indian Health Service Hospital are urban Indians, with the reminder of the users (15 percent) being Pueblo Indians from the nearby reservations.

A large portion of the justification of the Albuquerque Indian Health Service health care budget is supported by the 85 percent urban Indian user population statistics. However, when local tribes (primarily Pueblos) started to contract health care services, under PL 93-638), from the Albuquerque Indian Health Service, most of the funding went with these contracts, because, according to the Albuquerque Indian Health Service, these funds were intended for tribes rather than urban Indians who justify the budget with its user population numbers. Thus, PL 93-638 contracting has eroded much of the health care services to the urban Indian users. The Albuquerque Indian Health Service Dental Clinic, which has been basically reduced to nothing by "638" contracting was to be closed two years ago, but, through the efforts of Albuquerque urban Indian representatives and the New Mexico congressional delegation, an appropriation of $1.0 million was made by Congress in 2001 to keep alive minimal dental care services for the Albuquerque urban Indian community. All of the $1.0 million, however, did not reach the Albuquerque Indian Health Service Dental Clinic. The Albuquerque Indian Health Service diverted $500,000 to First Nations Healthsource to start a dental clinic there.

The diversion of the $500,000 is directly related to the provisions (or lack of) of PL 94-437, the Indian Health Care Improvement Act. According to a legislative liaison official

in the Indian Health Service Central (Washington, DC) Office, funding for urban Indians are funneled through Title V of PL 94-437. There apparently is no provision in "437" to fund urban Indian health care through an existing Indian Health Service facility, even though that facility (Albuquerque Area Indian Health Service) has been justifying its annual operating budget by including the urban Indian user count and, thus, receiving Congressional appropriation and funding directly for the Albuquerque Indian Health Service. So, the diversion of a portion of the $1.0 million intended for the Albuquerque Indian Health Service Dental Clinic presents a dilemma if the interpretation of the provisions of "437" is such that funding for urban Indians must go through Title V. Will the Washington Indian Health Service bureaucrats divert future appropriations for urban Indians again even though such appropriations are for the Indian Health Service facilities and not for urban nonprofit organizations?

This dilemma needs to be resolved before more funding is appropriated by Congress to the Albuquerque Area Indian Health Service for the Albuquerque urban Indian community. Albuquerque urban Indian representatives proposed insertion of new language to Title V, Section 512, of PL 94-437 and such new language has been forwarded to all New Mexico congressional delegation, as well as the Senate Indian Affairs Committee and the House Resources Committee and other congressional representatives. Again, this language (attached separately) is being forwarded for consideration by Congress to try to resolve the diversion by the Indian Health Service of appropriations intended for the Albuquerque Indian Health Service facilities (hospital or dental clinic) for provisions of health care services to Albuquerque urban Indians.

Requests for appropriations by Congress for the Albuquerque Indian Health Service Hospital and Dental Clinic have already been submitted over the past two years through the New Mexico congressional delegation, as well as directly to the Senate Indian Affairs Committee and House Resources Committee. The Albuquerque Indian Health Service Dental Clinic still lacks the $500,000 diverted to First Nations Healthsource and an additional $2.0 million to bring dental services back up to what it was before PL 93-638 contracting for the Albuquerque urban Indian community. Currently, the Dental Clinic provides services only to children and to adults on an emergency basis. The Albuquerque Indian Health Service Hospital needs approximately $7.0 million to replace funds contracted out under PL 93-638, which provided health care services to the urban Indian population. Without the additional $7.0 million, the Albuquerque Indian Health Service Hospital has reduced much of the health care services, much of it in the last three years.

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